The Objectives of NHS Trusts

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Tessa Crilly

London School of Economics

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Abstract of Thesis

This thesis explores the motivation and goals of NHS Trusts which were set up under statutory instrument from 1st April 1991 by Margaret Thatcher's Conservative Government and which continue to have a role under the Labour Government elected in 1997. The research question asks *'What are the objectives of Trusts? What is the extent of the constraints under which they operate?'*

The central piece of empirical work uses a questionnaire survey to explore individuals' objectives, yielding 1,577 responses. A second exercise uses cost and volume data to review the performance of 100 Trusts. A third strand uses a case study to consider the behaviour of Trusts within their external environment.

Consultants, or 'doctors', and managers are identified as the main power coalition within Trusts. Empirical findings are consistent with the hypotheses that, firstly, doctors and managers have different sets of objectives and that, secondly, doctors are interested in production, in particular maintenance of service quality, while managers are interested in the 'bottom line', defined as financial break-even. Under financial conditions described as 'bad times' where the interests of doctors and managers conflict, evidence suggests that doctors tend to dominate the performance of Trusts. It follows that Trusts will pursue a service objective, defined mainly through quality, rather than a financial goal. This dynamic is reinforced by the environment which sends signals to actors about how they should behave and, through lack of market exit, weakens the financial motivation of Trusts.

While such behaviour is coherent in terms of the dominant actors, it is at odds with the overall goals of the Trust organisation which are perceived by doctors and managers alike to be the single-minded pursuit of financial targets. The thesis finds that this driver is not owned or acted upon by either doctors or managers and that, in accordance with the balance of its internal motivation, the Trust's primary objective is to maintain service quality.

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CHAPTER 1. INTRODUCTION

This thesis investigates the objectives of NHS Trusts. It asks what Trusts are trying to achieve in their role as providers of health care, taking into account their internal characteristics and their national health service (NHS) environment.

The question of what Trusts are striving to achieve was stimulated initially by the internal market reforms introduced to the NHS on 1st April 1991 by Margaret Thatcher's Conservative Government. NHS Trusts were established as statutory bodies, independent of health authorities which up until then had been responsible for managing their services. The reforms were based on the White Paper *Working for Patients* (Department of Health, 1989) which excited widespread debate about the Government's proposal to introduce competition for the first time between providers of health care (Ham, 1992). Critics, including the then Labour opposition, predicted that quality of care would be put at risk as hospitals cut costs. They argued that Trusts would behave as businesses and would be motivated by profits in conflict with the interests of patients and the wider public. There was also concern that the reforms allowing 'self governing' Trusts to opt out of health authority control represented the first steps towards privatisation.

A further set of reforms has been implemented from 1st April 1998, this time by the Labour Government elected in May 1997, through the White Paper *'The New NHS: Modern . Dependable'*, (Department of Health, 1997). This ostensibly abandons market principles, arguing that *'The introduction of the internal market by the previous Government prevented the health service from properly focusing on the needs of patients. It wasted resources administering competition between hospitals'* (pp4-5). While the rhetoric of the internal market has been abolished, however, Trust status remains in place. Indeed, the concept of a Trust which is managed by its own Board has been strengthened by the White Paper: *'the Government recognises the intrinsic strength of decentralising responsibility for operational management. By giving NHS Trusts control over key decisions they can improve local services for patients. The Government will build on this principle and let NHS Trusts help shape the locally agreed framework which will determine how NHS services develop'* (p12).

Moreover, the White Paper proposals extend the domain of NHS Trusts to primary care through the formation a new type of organisation called Primary Care Groups (PCGs). These structures, bringing general practitioners and community nurses together with *'a budget reflecting their population's share of the available resources'* (p86), will have the opportunity to become free-standing Primary Care Trusts in the future, extending the number and resource-base of NHS Trusts.

It remains important, therefore, to try to gain some insight into what motivates Trusts, enabling policy makers to anticipate how Trusts will respond to new initiatives. This thesis considers Trust motivation in the context of the 1991-97 market environment and then draws

out the themes which will continue to have application in the post-1997 period of health service policy.

1.1 The Research Question

The speed with which the reforms were implemented was in spite of, or because of, a lack of piloting or research prior to 1991. Kenneth Clarke, in evidence to the House of Commons Select Committee, rebuffed the idea of formal monitoring and evaluation and suggested that to draw on academic advice was to display a degree of weakness (Health Service Journal, 1st June 1989).

One of the first evaluations of the reforms sought to assess the performance of Trusts by employing empirical and theoretical methods of research (Bartlett and Le Grand, 1994). It was observed that *'Trusts as such seem to have received remarkably little research attention'* (p54) and that empirical research had been *'almost completely atheoretical'* (p65) since it lacked an underlying model of Trust behaviour. The absence of such a model led to the framing of the research question for this study in terms of:

> *What are the objectives of Trusts? What is the extent of the constraints under which they operate?*

Motivation and the constraints under which Trusts operate may be considered in terms of the NHS environment which, for the period 1991 - 1997, has been described as a quasi-market (Le Grand and Bartlett, 1993). This differs from a conventional competitive market in a number of important respects. In a quasi-market people do not buy their own health care; instead an agency relationship is established, mainly through health authorities which purchase care on behalf of the patient. While the state purchases or funds care in a quasi-market it does not necessarily provide treatment, so that purchasing agents may commission health care from private hospitals. Monopolistic state providers are replaced by competitive independent ones which might not be seeking to maximise profits in accordance with conventional market theory. Finally, the financial regime in quasi-markets is often cash limited and annual as in the NHS.

The vocabulary and ethos of competition has changed with the Labour Government's abolition of the internal market (Department of Health, 1997) but the underlying structure of purchasing and provision has not, so that to all intents and purposes the quasi-market structures are intact. This type of market will work - i.e. achieve the ends of efficiency, responsiveness and choice without adverse consequences in terms of increased inequity - if a range of conditions is satisfied, defined as *cream-skimming, market structure, information, transaction costs, uncertainty* and *motivation* (Le Grand and Bartlett, 1993). The condition of 'motivation', explored in this thesis, requires that the suppliers of health care, namely Trusts or hospitals, are driven by a financial goal. This leads to the question of whether Trusts have, in practice, a strong financial drive and, if so, what is the nature of this goal?

There are a range of plausible objectives which may account for their behaviour. Simply balancing the books by matching income and expenditure may be the overriding goal since failure to do so would be laid at the door of the Chief Executive who would be called to account, either through the NHS Executive Region responsible for monitoring Trust performance, by the Trust Board or by the consultant body who, as precedents show[1], could oust the Chief Executive through a vote of no confidence. Alternatively, the Trust may aim to maximise service volume in order to fulfil its public service obligations and to meet other targets such as waiting lists and waiting times. In principle these objectives of service maximisation and financial balance could conflict, as illustrated in the following vignette which stimulated the research question:

> *In 1993 a District General Hospital in outer London, which had been a Trust for two years as part of the first wave, found that it faced a financial deficit in the year ahead. It had overperformed by up to 10% against its target volume of activity during the first two years of contracting but had succeeded in breaking even in both years (indicating that the real unit cost was less than the contracted unit price). In the third year of contracting, beginning 1st April 1993, the main purchaser reduced the contract value by 5%. The Trust management attempted to reduce the planned volume of service output to contain costs and fell into conflict with the consultants who resented constraints on their working practice through closure of theatre sessions and beds. The drive to maintain in-year financial balance was destined to produce short term reductions in total costs but higher average costs through introduction of structural inefficiencies within the hospital system.*

The atmosphere of disarray in a hospital such as this has no theoretical resolution. There is no model of behaviour which indicates whether a Trust would be driven to maximise its surplus, minimise its deficit, maximise its output or, indeed, pursue an entirely different goal. Accordingly, this thesis addresses the question of '*what are the objectives of Trusts*', taking into the account the motivation of consultants and managers working within the organisation and the external constraints operating upon Trusts in the NHS.

The District General Hospital which began to face a financial squeeze in 1993, its third year as a Trust, is in fact Kingston Hospital which is considered further as a case study in Chapter 11.

1.2 Structure of Thesis

The basic structure of the thesis is as follows. The next chapter describes the backdrop of events which led to the formation of Trusts in 1991. NHS Trusts are defined in terms of their statutory function, organisational content and role as producers of health care.

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[1] The Chief Executive of Royal Surrey County Hospital, Guildford, for example, resigned in 1992 after trying unsuccessfully to reverse a financial deficit and losing a vote of no confidence by the consultant staff.

Chapter 3 explores the literature of motivation according to four levels of analysis, starting with individuals working within the Trust, addressed mainly through the psychological literature. Groups within Trusts form the second unit, drawing principally on the sociological literature concerning relationships of power. Trusts themselves are considered at the third level in terms of aggregated individual and group motivation, but also as organisational structures and as separate economic entities according to the microeconomic theory of the firm. At the fourth level of analysis the chapter considers the environment in which Trusts operate, bringing in the role of the public sector and the question of market forces, expanding on some of the quasi-market characteristics identified in this introductory chapter.

The conclusions drawn from this survey of motivational theory are translated into a set of hypotheses about Trusts' objectives in Chapter 4. The chapter goes on to identify the methodological approach which will be used to test these hypotheses based on three strands of fieldwork: a questionnaire survey, a review of Trust performance data and a case study.

Chapters 5 to 9 present the findings of the main strand of empirical work contained in this thesis, summarising the results of a questionnaire survey which involved 1,577 respondents. The purpose of the questionnaire was to elicit views of individual doctors and managers about their own priorities and those of other groups within the Trust. These perceptions were analysed according to occupational and professional grouping. It was also possible to examine the attitudes of individuals towards 'the Trust' as an independent entity. The questionnaire was subjected to a developmental and trial period called Stage 1, the results of which are documented in Chapter 6. The national survey was launched as Stage 2 in September 1997, prior to the Labour Government's White Paper which was published in December 1997. A comparison of Stages 1 and 2 revealed potential methodological problems concerned with sample selection which may have produced bias in the results. This was addressed in Stage 3 which replicated the earlier pilot (Stage 1) and formed a comparative case study. The three chapters 6 to 8 deal with the quantitative results of the questionnaire enquiry, summarising the responses to the closed questions which produced frequencies, ratings and ranking scores. Qualitative material was also collected through the questionnaire survey using a series of open questions. The range and volume of responses which emerged when individuals used free text was extensive; the process of coding and analysis of open questions was applied to the large sample base provided by the national survey (Stage 2) and is presented separately in Chapter 9. The results of this questionnaire survey test the hypotheses relating to motivation and perceived control of groups within Trusts.

The motivation of actors cannot be observed directly, but its impact will be revealed through their actions, determining the goals and behaviour of Trusts. Chapter 10 tests the hypotheses by attaching the results of the attitudinal survey to specific performance measures of Trusts, defined as achievement of financial targets and expansion of services within the Trust. This takes forward the internal motivation of the organisation to its manifestation through behaviour.

The final element of fieldwork takes the form of a case study, described in Chapter 11. The model of motivation which starts from internal dynamics of Trusts (Chapters 5 to 9) leading to goal-driven behaviour (Chapter 10) is ultimately modified by the feedback which is derived from the environment. For NHS Trusts the environment is the local health economy which provides a forum for interaction between neighbouring Trusts and purchasers. The case study takes a chronological view of events in south west London, with Kingston Hospital as the focus of attention, and considers the influences which are external to the Trust, such as parliamentary politics and pressures from professional bodies.

Chapter 12 concludes the thesis by summarising the results of the fieldwork and setting them within the new policy framework established by the Labour Government.

CHAPTER 2. CONTEXT

This chapter describes the context in which Margaret Thatcher's Government developed proposals for reform of the health service in the late 1980s. It gives details of the changes wrought by these reforms and defines the nature of NHS Trusts, in terms of their statutory obligations, organisational characteristics and economic boundaries.

2.1 The Case for Change

In spite of strong opposition to the 1989 White Paper, a case for change was already established which enabled supporters to argue with conviction that 'something must be done'.

When the NHS was established in 1948, it was generally assumed that expenditure on health services would decline with the eradication of the backlog of ill health believed to exist in the community at the time (Glennerster, 1995). But, contrary to this assumption, expenditure on the NHS has increased steadily, rising from 3.9% of GDP in 1949 to 5.9% in 1988 (Ham, 1992) with a four-fold increase in the real cost of the NHS:

Table 2.1: Health Service Costs, Years 1949 - 1988

Year	*Total Cost of NHS*	*Cost at 1949 Prices*
	£m	*£m*
1949	437	437
1988	23,627	1,797

(Source: Ham, 1992, p39)

When expenditure is forecast to the year 2000 (Source: Health Service Journal Map of the National Health Service, 1999), the growth from 1988 is equivalent to the cost of another two National Health Services at 1949 prices.

Table 2.2: Health Service Costs, Year 2000

Year	*Total Cost of NHS*	*Cost at 1949 Prices*[2]
	£m	*£m*
2000	45,000	2,819

(Source: HSJ Map of the NHS 1999 based on DoH Departmental Report 1999-2000)

Debate continued about the actual level of funding of the NHS and its adequacy to maintain and develop services (e.g. Robinson and Judge, 1987; Institute of Health Service Management, King's Fund Institute, National Association of Health Authorities, 1989).

[2] Method: Deflate difference between 1988 and 2000 prices by 3.5% per year (i.e. 0.96512); apply figure as % of 1998 prices to 1949 equivalent; add to 1949 equivalent; i.e. reflect 1988-2000 increase in 1988 prices and then relate to 1949 prices.

Nevertheless, expenditure on Hospital and Community Services slowed during the 1980s in line with the policy of the Conservative Government. Ham (1992) estimates that real spending on Hospital and Community Services rose by less than 1% per annum during the period 1980-90, compared to a target requirement of 1.3%-2.3% per annum identified by the government as necessary to fund demographic, technological and service developments. On this basis the cumulative shortfall 1981-1988 amounted to £1.8 billion.

Health Service underfunding became a topic of public debate. The National Association of Health Authorities reported that authorities were closing beds to deal with financial pressures (NAHA, 1987). The BMA called for additional funds, and the presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians and Gynaecologists issued a joint statement calling for improved funding to avert a crisis in the NHS (Ham, Robinson and Benzeval, 1990). Highly publicised events such as the death of Baby Barber in Birmingham through apparent lack of intensive care beds continued to rock the public's confidence in the NHS.

The Government, which so far had taken the position that the NHS made poor use of resources (manifest through, for example, Rayner scrutinies into efficiency and introduction of Cost Improvement Programmes), responded by promising a wide-ranging review of the future of the NHS. This was announced by Margaret Thatcher in a Panorama programme in January 1988 with a commitment to publish the results within a year.

Kenneth Clarke became Secretary of State for Health in July 1988 and played a major part in the preparation of the White Paper, *Working for Patients*, which was published in January 1989 (Department of Health, 1989). It announced that the NHS would continue to be funded mainly out of taxation and that the service would continue to be free at the point of delivery. Change would be wrought in the means of delivering care through an injection of market forces between hospitals and community services in the construction of what became known as a 'quasi-market' for health care (Le Grand and Bartlett, 1993).

2.2 The 1991 Reforms

Up until 1991 all hospital and community services had been funded by their local District Health Authority which received a budget allocation set by the Regional Health Authority. The service providers, described as hospital and community units, received a budget determined by historical spend with changes at the margin to reflect movements in revenue allocations to the Health Authority. The most senior manager in the hospital was described as the Unit General Manager (or Hospital Administrator prior to the Griffiths reforms in the mid 1980s) who reported to the District General Manager based at the Health Authority. It was understood that catchment or 'planning' populations differed from resident populations of health authorities due to cross-boundary flows of patients. This would have an impact on historical spend but was not usually funded explicitly.

The internal market reforms of 1991 made a distinction between the purchasers and providers of health care, both in terms of management and of funding. Providers were given the opportunity to become NHS Trusts, described in the White Paper as having self governing status, managed by a Chief Executive who would report to a Trust Board which, at that time, was accountable directly to the Department of Health and, later, to the Region. With these reforms the District Health Authority lost its hospital management function but assumed responsibility for the health of its resident population by purchasing services on its behalf. This purchaser-provider split required hospitals to gain their income by means of contracts with health authorities specifying the number of patients to be treated and the price of different types of treatment.

The funding route was restructured so that health authorities received allocations to reflect the treatment pattern of patients who were resident within their borders, even if they were treated elsewhere. The hospitals engaged in contracts to recover the cost of patients directly from the health authority of residence. In the first year the transition between the old and new funding structure was achieved through a device called 'steady state'. It determined that funding for a hospital in the year beginning 1st April 1991 would be exactly equal to that of the previous year, even though it was being recovered from perhaps a dozen rather than one health authority.

By setting prices through the contracts it was envisaged that hospitals would compete with each other based on price and that efficient hospitals would attract more patients and therefore more income, on the basis that money would follow the patient. As the White Paper expressed it, *'[a]n NHS Hospital Trust will earn its revenue from the services it provides. The main source of revenue will be from contracts with health authorities for the provision of services to their residents. Other contracts and revenue will come from GP practices with their own NHS budgets, private patients or their insurance companies, private hospitals, employers and, perhaps, other NHS Hospital Trusts. This form of funding will be a stimulus to better performance. There will be an opportunity to finance improved and expanded services because the money will flow to where the patients are going. Hospitals which prove popular with GPs and patients will attract a larger share of NHS and other resources available for hospital services. A successful hospital will then be able to invest in providing still more and better services. Contracts will need to spell out clearly what is required of each hospital in terms of the price, quality and nature of service to be provided. A hospital which fails to meet the terms of a contract will risk losing patients and revenue.'* (Department of Health, 1989, p24).

It was envisaged that NHS Trusts would be different and special since they would have powers which would not be generally available. *'NHS Hospital Trusts will be a novel part of a system of hospital care alongside health authority-managed and private sector hospitals, and will increase the range of choice available to patients and their GPs'* (Department of Health, 1989, p25). The then Secretary of State, Kenneth Clarke, did not expect Trust status to become widespread: '*We didn't think we'd get very many. The object was to get them*

going and then make them the envy of the service ... I saw a slower pace of spread' (Timmins, 1995, p469). By May 1990, however, rather than ten or twenty hospitals there were 140 expressions of interest in self-governing Trust status, *'almost all of them promoted by managers and some actively opposed by their hospital's doctors'* (Timmins, 1995, p469).

The vocabulary of the 1989 White Paper included the word 'business' by asserting that management bodies would *be 'reformed on business lines with executive and non-executive directors'* (Department of Health, 1989, p5) but there was no reference to business failure, hospital closure or exit from the market. The tenor of expectation lay in extending choice, delegating responsibility to where the services were provided and in securing the best value for money. *'NHS Hospital Trusts will earn revenue from the services they provide. They will therefore have an incentive to attract patients, so they will make sure that the service they offer is what their patients want'* (p4). *'Supported by a funding system in which successful hospitals can flourish, it [self-government] will encourage local initiative and greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered'* (Department of Health, 1989, p22).

2.3 The NHS Trust

This section describes the growth and composition of Trusts. It goes on to identify the statutory duties of NHS Trusts and then outlines some of their internal features.

2.3.1 The Growth and Composition of Trusts

On 1st April 1991 a 'first wave' of 57 NHS Trusts was established and by the sixth wave in 1996/97 there were 429 Trusts in England, 30 in Wales, 47 in Scotland and 20 in N. Ireland (Fitzhugh, 1998). During this period NHS Trusts grew to encompass the whole of the hospital and community service within the NHS, forming the supply side of all secondary and community care.

The growth in Trusts in England between April 1991 and March 1997 is set out in the table below, followed by an analysis of the 1996/97 Trust composition.

Table 2.3: Growth in Trusts in England 1991-97

Financial Year	*Wave*	*No. Trusts*	*Core Income £m*	*No. Staff*	*Assets £m*
1991/92	1	57	2,602	108,646	2,939
1992/93	1,2	156	6,539	266,980	7,073
1993/94	1,2,3	292	12,423	483,971	13,607
1994/95	1,2,3,4	419	18,494	698,630	19,141
1995/96	1,2,3,4,5	433	20,102	717,806	21,707
1996/97	1,2,3,4,5,6	429	21,127	724,331	22,801

(Source: Fitzhugh, 1998)

Table 2.4: Trust Composition in England 1996-97

Category Description	*No. Trusts*	*Core Income £000*	*No. Staff*	*Fixed Assets £000*	*% Trusts*	*% Income*	*% Staff*	*% Assets*
1. Multiple Activity	64	4,134,926	143,290	4,769,715	15%	20%	20%	21%
2. General Acute Unit	152	10,439,447	346,331	12,166,907	36%	49%	48%	53%
3. District Community Service	115	4,209,424	152,828	3,556,601	27%	20%	21%	16%
4. Mental Health & Learning Disability Service	40	1,147,851	41,990	1,128,967	9%	5%	6%	5%
5. Specialist Hospital	23	615,168	18,116	765,722	5%	3%	2%	3%
6. Ambulance Service	35	580,678	21,776	413,319	8%	3%	3%	2%
Total	429	21,127,494	724,331	22,801,231	100%	100%	100%	100%

(Source: Fitzhugh, 1998)

In the context of this research Trust organisations are characterised mainly as hospitals. The emphasis upon hospitals rather than community services is warranted on the basis of scale since in 1997, for example, 49% of expenditure was linked to general acute units (see '% income' in table above) with a further 23% linked to specialist hospitals or multiple activity Trusts which are also mainly hospital-based. 5% of income was accounted for by mental health and learning disability Trusts, within which two thirds of resources are dedicated to hospital services (Audit Commission, 1994). Only 20% of income related to community Trusts, many of which would include community hospitals. (The remaining 3% of hospital and community services funding is accounted for by ambulance services which are not addressed at all in this work.)

2.3.2 The Statutory Duties of the Trust

NHS Trusts were established through statutory instrument by the Secretary of State for Health under the National Health Service and Community Care Act 1990, separating the responsibilities and assets of Trusts from those of District Health Authorities which had formerly managed them. The Act stated that Trusts were to be run by a board with a

chairman appointed by the Secretary of State; boards would contain up to ten members with equal numbers of executive and non-executive directors; executive directors must include the Chief Executive, medical director, senior nurse manager and a finance director; revenue would be earned through contracts for services; Trusts would be free to set local terms and conditions for all employees, including medical consultants; Trusts would be given capital debt equal to the value of their initial assets and would be free to dispose of their assets (subject to a reserve power of the Secretary of State), and to borrow from the Government or private sources.

Trusts continue to exercise their financial freedoms within a regime which regulates the return on capital, access to capital, level and structure of prices charged through contracts and the level of operating costs. The NHS Executive, on behalf of the Secretary of State, requires Trusts to:

- break-even on operating costs;
- achieve an external financing limit (EFL), agreed by the regulator[3], which determines the total resource allocation, i.e. both capital and revenue, to be expended by the Trust[4];
- set prices for NHS services which ensure that all costs including depreciation and 6% return on assets are covered;
- set a price structure ensuring no cross-subsidisation between activities;
- achieve Value for Money, i.e. productivity increases, measured by purchasers through the Purchaser Efficiency Index (a formula defined by the Department of Health).

Most of the freedoms of a Trust are managerial and within year and have been heavily circumscribed by the regime which at the outset did not permit them to make or save surpluses. Although the White Paper *Working for Patients* had promised in 1989 that Trusts would be free to retain surpluses, to build up reserves with which to improve services and finance investment, and to manage any temporary deficits, in the event Trust freedoms proved to be more limited than originally envisaged by the White Paper's authors. Financial targets set by the annual External Financing Limit proscribed Trusts' ability to retain surpluses or manage deficits from 1st April 1991. Likewise, the Value for Money test ensured that the opportunity to borrow from private sources was weak in practice since the Government provided the cheapest source of borrowing, so that on financial grounds alone it would be impossible to make a case for private sector fund-raising. Funds for restructuring of costs and services are required to be sought from the purchasers through price increases, posing a particular problem where the Trust is located in a capitation-losing area. Capital investment is allocated through adjustment of the EFL based on a business case submitted to the Region or Treasury (depending on the scale of the bid). The allocation process takes account of purchaser support.

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[3] Originally the function of *Trust-Outposts* but later subsumed by the *Regional Offices*, now functioning as the regional branches of the *NHS Executive*.

[4] Private sector-sourced funding was also counted against the EFL as a means of controlling public expenditure on health nationally.

Central policy directives continue to guide the behaviour of Trusts in all spheres, e.g. Private Finance Initiative, New Deal for Junior Doctors' Hours. Managerial discretion is further constrained by rules set by the professional bodies such as the Royal Colleges which grant recognition for training of medical staff.

The 1997 White Paper has altered the detail of some of the Trust's duties, for example (a) by '*replacing the Purchaser Efficiency Index from 1 April 1999 with measures based on [a] new broader performance framework*' (p65), but not in removing the obligation to achieve efficiency, and (b) by recommending the use of three year agreements (p48) while retaining the purchaser-provider contracting structure. It also introduced an explicit change of tone and emphasis, stating that *'market-style incentives drove NHS Trusts to compete to expand their 'business' irrespective of whether this reflected local NHS principles. Their role was further distorted by the almost exclusive emphasis on their statutory financial duties'* (Department of Health, 1997, p44). This suggests a change in the role of Trusts with a shift towards non-financial objectives through *'clinical governance arrangements [which] will be developed in every NHS Trust to guarantee an emphasis on quality'* (p45).

2.3.3 Internal Features

Trusts can be understood in terms of their resources and their organisational structure. Drucker (1993) observes that, although 'organisation' has become an everyday term and that society in all developed countries has become a 'society of organisations' in which most social tasks are done in and by an organisation (e.g. business, trade union, hospital, school), the term has gained its current meaning only since World War II. An organisation can be described as a man-made construct which groups humans together to work on a common task. An organisation is specialised and defined by its task which, in the case of NHS Trusts, is delivery of healthcare.

Trusts are labour-intensive since 72% of NHS costs relate to staff (Department of Health, 1997) which, according to Department of Health guidelines (1993b) are fixed or semi-fixed. Typically the cost structure is: Fixed 28%, Semi-Fixed (mainly staff) 61%, Variable (e.g. drugs) 11%. Set-up costs of hospitals are high due to investment in capital and equipment including theatres, pathology laboratories and imaging facilities.

National data serves as a proxy for Trust-specific data in examining the structure of the workforce. In 1998 the NHS in England employed 765,000 whole time equivalent (wte) staff in hospital and community services (Department of Health 1999a) with a balance between staff groups as follows:

Table 2.5: NHS Workforce 1998

Medical & Dental	8%
Nursing, Midwifery (exc P2000 learners)	44%
Scientific, Therapeutic & Technical	13%
Healthcare Assistants	3%
Support Staff	8%
Ambulance	2%
Administration and estates staff	22%
Total	100%

(Source: Department of Health 1999a)

These figures would not reflect non-NHS employees such as ancillary and maintenance staff in outsourced services, agency nurses or locum doctors. The major input to the service is from professionally qualified staff and within the groups above the proportions of qualified staff are:

Table 2.6: Professionally Qualified NHS Workforce NHS 1998

Medical & Dental	100%
Nursing & Midwifery (exc education)	74%
Nursing & Midwifery (inc education)	67%
Professional & Technical	82%

(Source: Department of Health 1999a)

Although medical staff are one of the smallest staff groups, less than 50% of whom are consultants, they represent a major power base within the NHS. 'Administration' is a large collective group which includes managers. Much of the organisational change within the health service during the 1980s and 1990s has been an attempt to redefine the balance of power between the two groups, i.e. to enable managers to manage and also to bring doctors into management. The Griffiths report into general management (1983) and the Resource Management Initiative (Department of Health and Social Security, 1986) paved the way for the management restructuring associated with adoption of Trust status after 1991.

The NHS introduced a 'clinical directorate model' of hospital management from 1984 onwards which began with an experiment in Guy's Hospital and was extended to the rest of the NHS in the form of the Resource Management Initiative (RMI). In this model the hospital was divided into clinical directorates along specialty lines, e.g. surgical specialties, medicine, women and children's health, and clinical support such as imaging (radiology), pathology and theatres. The clinical director would usually be a member of the consultant medical staff, using one or two clinical sessions to undertake management responsibilities, and responsible to the hospital general manager, later the chief executive. Clinical directors would normally be supported by a manager, described throughout this thesis as a

service/business manager. The clinical directorate model represented a devolved form of management, intended to locate decision-making as close as possible to the point of service delivery. The purpose of the clinical directorate model was:

> *'to reconcile clinical freedom with management authority and accountability ... the consultants agreed to accept a system that sought to equate power with responsibility. In return for the freedom to manage their own affairs, they had to accept responsibility for the financial consequences.'*
>
> Smith and Chantler, quoted in Harrison & Pollitt (1994) p90

2.4 Conclusion

This chapter has set the context in which NHS Trusts function, observing that:

- The case for change in the health service was well established as a precursor to introducing reforms in 1991;
- By the sixth wave in 1996/97 NHS Trusts accounted for the supply of all secondary and community care in the health service;
- Trusts have well defined statutory duties, set initially in terms of financial requirements. Since 1997, with the new Labour Government, financial objectives have been combined with a duty to provide high quality services through the introduction of clinical governance;
- Trusts are labour intensive organisations with a high concentration of professional staff;
- Trusts each have a Board of Directors with a prerequisite membership including, for example, the Chief Executive and Medical Director. The organisations have a common type of management structure, described as a 'clinical directorate model', which was intended to facilitate devolved management with a clinical lead. The managers of clinical directorates are described as service/business managers in this thesis and are a key unit of analysis.

The management structure of Trusts is addressed explicitly through the fieldwork in Chapters 5 - 9. Chapter 3 which follows builds up a framework of motivation using broader units of analysis, namely individuals and groups within Trusts, before considering the organisations themselves in their environmental setting.

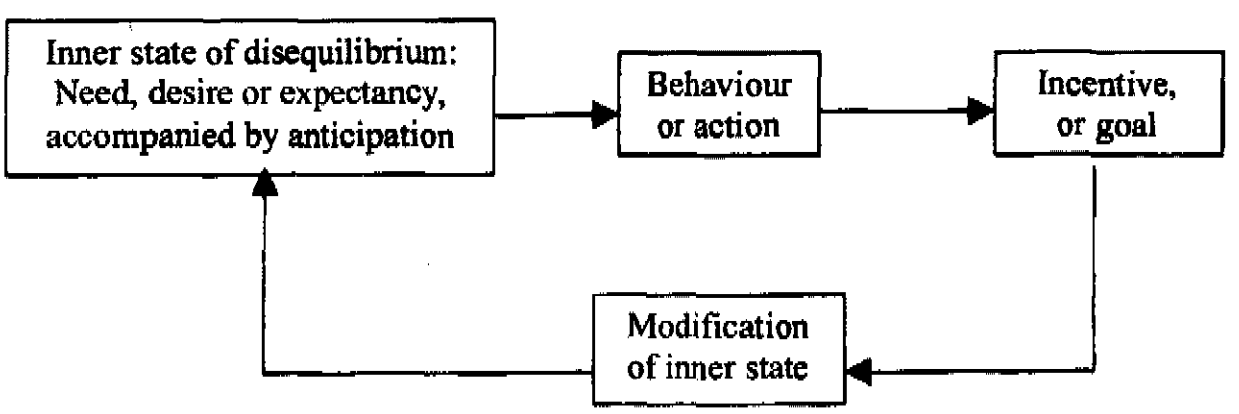
CHAPTER 3. MOTIVATION OF TRUSTS: A FRAMEWORK

In considering the motivation of Trusts this chapter looks at the motivation of hospitals and the people working within them by using four levels of analysis: individuals, groups, NHS Trusts and the external environment within which Trusts operate. This structure permits a logical development, taking forward the impact of individual motivation into the groups interacting within the Trust which are in turn affected by their environment. Evidence across the social sciences is reviewed to generate a set of hypotheses about motivation of Trusts.

3.1 Motivation in Individuals

The term 'motivation', derived from the Latin *movere* meaning 'to move', is concerned with the question of what energises, directs and sustains behaviour (Steers and Porter, 1991). Energetic forces imply an inner drive which motivates individuals or external forces within the environment which trigger these drives. The notion of being directed towards something implies a goal orientation or set of objectives. The third element, the sustaining element, suggests the need for feedback to enable individuals to maintain or alter their objectives in the light of experience. This cycle is depicted in Figure 3.1 below.

Figure 3.1 : A generalised model of the basic motivation process (after Steers and Porter, 1991)



The model is simplistic since motives can only be inferred and cannot be seen, and at any one time a host of motives may be in conflict with each other. There will also be differences between individuals in the way they select their dominant motive, and satisfaction of goals may have an impact on subsequent motives and behaviour. The intensity of certain motives, such as hunger, thirst or sex, is generally reduced upon gratification while others, such as the desire for more money or power, may be heightened by their attainment. A further caution in considering theories of motivation is that the academic literature is culture bound, since *'[m]ost motivation theories in use today were developed in the United States by Americans and about Americans. ... they reflect the values system of Americans'* (Adler, 1991, p324). With these limitations in mind, the literature review considers psychological, managerial and economic approaches to individuals.

3.1.1 Psychological Approaches to Motivation

The principle of *hedonism,* that pleasure will be sought over pain, lies at the root of most psychological theories of motivation. It dates back to the early Greek philosophers and re-emerged in the works of philosophers such as Locke, Bentham (who coined the term 'hedonic calculus' in 1789 to describe the weighing of pros and cons of various acts of behaviour), Mill and Helvetius (discussed in Cherrington, 1991). Toward the end of the nineteenth century the empirically based science of psychology overtook philosophy as a means of exploring motivation. Psychologists such as Freud (1920) and McDougall (1908) emphasised the role of instinct and unconscious motivation in which individuals were perceived as having innate predispositions towards certain behaviour in response to internal and external cues. Critics of instinct theorists argued that much behaviour was learned rather than instinctive, and so developed a new school which developed drive and reinforcement theories[5]. Woodworth (1918) first introduced the term 'drive' to describe the supply of energy that impels an organism towards certain behaviour, leading to identification of a range of drives such as hunger. The notion of homeostasis (Cannon, 1939) was developed to describe the need to alleviate any disequilibrium or deviation from the normal state by, for example, satisfying hunger. Cognitive theories formed the third major line of development in psychological approaches to motivation. Unlike drive theories which represented behaviour as a function of the past, cognitive theories saw motivation as a 'hedonism of the future' which was driven by anticipation of future events and led to goal-directed behaviour. Tolman (1932) and Lewin (1938) were early exponents of the expectancy or valence theories in which individuals were viewed as choosing behaviours by firstly determining their potential outcome and secondly attaching a value to these outcomes. Cognitive theories vary from drive theories since they see the individual as selecting their drivers based on expectancy, rather than being subjected to non-selective influences. Both, however, stress the importance of some sort of goal orientation in terms of a reward or expected outcome. Both, also, use the idea of learning, either through past stimulus-response associations or through behaviour and outcome.

Theories which describe the inner state of the individual have encompassed physiological needs which, when fulfilled, give way to a need for self-actualisation. Figure 3.2 compares Murray's inventory of needs (1954) with Maslow's (1954) and Alderfer's (1969) hierarchies of need.

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[5] The concept of instinct is undergoing a renaissance in the biological sciences through neo-Darwinism which uses the metaphor of the *selfish gene* (Dawkins, 1976) to explain biological and social behaviour. The life-cycles of humans, plants and animals are interpreted as being driven by an innate instinct towards gene replication and survival. This has been extended to other populist scientific publications, such as Tippler's *Physics of Immortality* (1994) which suggests that space travel is inevitable in the human drive to broadcast genes throughout the universe.

Figure 3.2: Comparison of Need Theories (based on Cherrington, 1993)

Murray *(No Hierarchy)*	**Maslow** *(Hierarchy or Prepotency)*	**Alderfer** *(Hierarchy but can be simultaneously active)*	*Top of Hierarchy*
Psychogenic: Abasement Achievement Affiliation Aggression Autonomy Deference Dominance etc	**Self-Actualisation**	**Growth**	
	Esteem		
		Relatedness	
Viscerogenic: Food Water Sex Urination Defecation Lactation	**Social**		
	Safety		
	Physiological	**Existence**	*Bottom of Hierarchy*

McClelland (1965) investigated three of Murray's needs: achievement, affiliation and power, and classified individuals according to the strength of their needs in these areas, abbreviated as 'nAch', 'nAff' and 'nPow'. High need achievers were found to have a strong desire to assume personal responsibility for performing a task or finding a solution to a problem. If the task required the presence of others they would tend to choose coworkers based on their competence rather than friendship and would set moderately difficult goals, taking calculated risks. High-need achievers have a strong desire for performance feedback, regardless of whether they have succeeded or failed. Money is not a strong motivator, since these individuals are already highly motivated, and instead acts as a form of feedback and recognition, providing evidence of success. McClelland argued that the achievement need could be taught and developed through cognitive support and reinforcement. The need for affiliation - nAff - is defined as a desire to establish and maintain friendly and warm relations with other individuals, seeking approval and tending to conform to the wishes of friends. The need for power - nPow - is defined as the need to control others, to influence their behaviour and to be responsible for them. It is tempting to use this classification to categorise doctors and managers. One could speculate that doctors tend towards 'nAch', Chief Executives towards 'nPow' while middle managers who need to manage relationships would tend to work as 'nAff' types. There is no evidence to support this hypothesis, however, and the value of the theory in this context is to highlight the potential differences between individuals and their underlying motivation.

Deci and Ryan (1985) argued against the body of psychology literature which viewed all behaviour as being driven by goals, reinforcements and environmental contingencies and which denied the existence of intrinsic motivation. They emphasised the role played by feelings and joyful experience in stimulating the individual towards autonomy and self-direction. Deci and Ryan, along with Harter (1978), Angyal (1941) and deCharmes (1968)

argued that the need for competence and self-determination (or effectance) prompts individuals to seek and conquer challenges which stretch their capacity. Child development could be interpreted in this light where, for example, competence produces satisfaction and pleasure in the act of walking but over time needs to be stretched to the next stage to prevent boredom from setting in.

Csikszentmihalyi (1975) went further in arguing against anticipated goal-driven behaviour. *'Chatting with acquaintances, daydreaming, ... drumming with fingertips on tabletops'* (Csikszentmihalyi, Chapter 10, p209 in Lepper and Greene, 1978) were given as examples of non-goal driven behaviour which were essential to mental balance. He suggested that enjoyment of the activity was reward in itself and did not need to be stimulated by any external, future goal. 'Free will' on the part of the actor produced motivating power, rather than genetic evolution or social conditioning. The discovery of new goals and experiential rewards defined the 'emergent' state of the organism and produced creativity. True enjoyment, he postulated, is accompanied by the experience of 'flow' where one is immersed in the task and experiences a loss of ego and unity with time and surroundings. *Flow* experiences may occur in games, sports, rituals, meditative states and aesthetic experiences and Csikszentmihalyi's research suggests that flow emerges under specifiable states, the most important of which is optimal challenge. This occurs when the individual works to the peak of capacity and is engaged in an optimally challenging activity, i.e. one that is not too easy. This links with Deci and Ryan's notion of competence since Csikszentmihalyi concludes that *'the whole issue of intrinsic rewards eventually boils down to this - the acquisition of skills'* (p211). (This has resonance in the fieldwork later where surgeons indicate that they just want to carry out their tasks as efficiently as possible).

3.1.2 Managerial Approaches to Motivation

Managerial attention to the role of motivation in organisations began as a consequence of the industrial revolution. Employers became interested in ensuring an efficient workforce to yield a return on capital investment in large-scale and complex factory operations. 'Good' workers were seen as pursuing their own best economic self-interests, leading to a philosophy of management sometimes described as the 'traditional' model of motivation (Steers and Porter, 1991).

The 'traditional model', characterised by the Scientific Management approach developed by Frederick Winslow Taylor (1911), has exerted a continuing influence on organisational design and management practice. It originally focused upon the shopfloor and on the techniques that could be used to maximise the productivity of manual workers. This approach to motivation rested on the basic contemporary assumptions about the nature of human beings, namely that they were lazy, often dishonest, aimless, dull and, most of all, mercenary. The aim of 'scientific management', through systematic study of work, was to achieve the 'one best way' of performing the job, and raise efficiency for the benefit of all, guided by a set of 'great underlying principles of management'. The underlying motivational

assumption was that, for a price, workers would tolerate the routinised, highly fractionated jobs of the factory and that incentive structures would determine output.

Taylor's methods have been followed by others including Gantt, Frank and Lillian Gilbreth, Bedaux, Rowan and Halsey, and have been developed into what is now called Work Study or Industrial Engineering and, more recently, Business Process Re-engineering (e.g. Hammer and Champy, 1993). Taylor has been a controversial figure, even in his lifetime, due to the alleged inhumanity of his system which was said to reduce workers to the level of efficiently functioning machines. The quest for profits led managers to put constraints on the incentive system to the point where workers' output was rising without corresponding increases in wages. Productivity gains meant that fewer workers were required while workers countered this with restrictive practices and growth in trades unionism. Organisations began to review their motivational assumptions about employees in an effort to increase production and maintain a steady work force. Newer approaches did not, however, eliminate the primary economic assumption of the traditional model, and recent studies among both managers and workers indicate that money is a primary motivational force and that many workers will select jobs more on the basis of salary prospects than job content (e.g. Lawler 1973, Mobley 1982). *'Overall, organisations that give the greatest rewards tend to attract and retain the most people'* (Lawler, 1991, p507).

A second model of behaviour and motivation is approached through the human relations movement which, drawing heavily on the Hawthorne studies conducted between 1927 and 1932 (Roethlisberger and Dickson, 1939), concluded that economic considerations were relatively unimportant in motivating workers and in raising productivity and, instead, solidarity was the key. Subsequent research was carried out using interviewing and observation-based data collection methods. Taken as a whole, the significance of the Hawthorne investigation lay in discovering the existence of the 'informal organisation' and demonstrating the importance to individuals of stable social relationships in the work situation. Huczynski (1993) argues that the human relations movement arose from the American wish to humanise their society without interfering with the free operation of market forces. Competition outside the firm was considered desirable but was to be avoided within the firm. Human relations can be interpreted as a reaction to scientific management or, alternatively, as a different tactic which sought to achieve the same goal of destroying work group solidarity.

The human relations message can be reduced to a set of propositions which amount to 'being nice to workers'. The message to managers was that, while the informal group captured the individual, the firm could capture the informal group since workers were psychologically vulnerable to any group which exhibited social concern for them. If workers could be helped to belong, human relations would be improved and the workers made more productive. The growth of unions and evident general discontent of workers, together with a growing sense of responsibility among managers, meant that the 'human factor' taking into account the 'whole person' added considerable appeal to management theory.

Neo-Human Relations (NHR), a popular group of ideas otherwise described as the 'human resources model' (Steers and Porter, 1991), represents an ideal of 'empowering' individuals by recognising the complexity of their needs and of humanising work in the face of rapid social and technological change. It assumes that employees' attitude to the company would become entirely positive if they were allowed to do responsible and meaningful work, and that they would come to share the goals of management, thus bringing an end to industrial conflict. By eliminating hierarchy and specialisation, people would be given room to grow and would become involved in a co-operative process. Neo-human relations represents a return to dealing with the individual rather than the group, and calls upon employees to return to self-reliance and the Protestant work ethic within the sphere of control of the organisation. Influential NHR theories, as categorised by Huczynski (1993), include Maslow's needs hierarchy (1943), McGregor's Theory X and Theory Y (1960) and Herzberg's Hygiene Motivation Theory (1959). Theory X assumptions are that average human beings inherently dislike work and need as a result to be coerced, directed and threatened with punishment to get them to work. Theory Y postulates that work is as natural to the average human being as rest or play and the individual can be self-directing when committed to the objectives served. In contrast to the traditional and human relations models which identify managers' tasks as being one of manipulating employees to accept managerial authority, the NHR management task is of setting up conditions to enable employees to meet their own personal goals at the same time as meeting the organisation's goals.

The traditional model (or Scientific Management), Human Relations, and Neo-Human Relations form three popular 'management idea families' identified by Huczynski (1993) on the basis of *'a survey of academics and practitioners in the field and a content analysis of professional journals, popular texts of selected readings and a reprint series'* (p3). In considering the popularity of these groups of ideas Huczynski acknowledges the significance of the world of management consultancy and training which requires 'touchstone ideas' for its own legitimation and development and which imposes constraints on the nature and form of evolving management ideas. Key aspects of organisational life, such as its political nature, thus tend to be excluded. A second limitation relates to how the management idea can be packaged and sold:

> *Those that succeed are likely to be presented in the form of logos or pseudo-theoretical models which form the basis of a two or three day training programme. Thus, pragmatic ideas in the form of McGregor's 'Theory X and Theory Y', Maslow's 'Hierarchy of Needs', Herzberg's Motivators and Hygiene Factors' and Peters and Waterman's '7-S' model will be included. All of these can be summarised on one page of a course handout in the form of a logo or on an overhead projector transparency.*
>
> A. Huczynski, *Management Gurus*, 1993 (p5)

The contingency approach to management and motivation, which falls outside this set of 'popular' ideas, rejects the need to follow any single model. The 1960s represented a

watershed in thinking as empirical work began to raise questions about the validity of the organisational principles preached by management theorists. Rejection of universal prescriptions established the contingency approach (among the research community) which aimed to identify the organisational design that 'best fitted' the situation as it existed. Contributions came from research into diverse topics such as wage payment systems, leadership styles, organisational structures, environmental influences and job design. The common feature across this range was a rejection of any 'one best way', substituting an emphasis on diagnosis of the situation to determine which approach would be more useful and appropriate under the particular circumstances.

3.1.3 Economic and Welfare Approaches to Motivation

The classical and neoclassical economic view of humanity is consistent with the traditional managerial view of the mercenary worker and of the psychological view that man is goal-oriented, based on learned or instinctive drives. *Homo economicus* is a rational individual who acts out of self-interest towards financial (or psychic) gain.

This view of motivation has been heavily criticised within the social sciences community, most notably by Richard Titmuss (1970; Oakley & Ashton, 1997). In his celebrated work '*The Gift Relationship*' he challenged the concept of *homo economicus* by comparing the practice of voluntary blood donations with the commercial approach of paying individuals to supply blood banks. His study was a riposte to Cooper and Culyer (1968) who argued that a financially driven market for blood should be introduced to increase supplies and raise productivity. Titmuss countered that use of cash payments would diminish the altruistic motivation of individuals and so lead to inferior quality and quantity of blood. In essence, introduction of market forces would shift the nature of the donor from that of altruistic, well-meaning individual to that of *homo economicus* who would have every incentive to contaminate the blood supply by lying about hazardous illnesses in their past such as hepatitis B.

Le Grand (1997) translated this observation into the language of 'Knights, Knaves or Pawns' in which, following Hume (1875)[6], individuals motivated by their own self-interest are described as Knaves and the self-denying, altruistic individual as a Knight. Introduction of market incentives into the environment has the potential to turn a Knight into a Knave, consistent with the work of Lepper and Green (1978) and Deci and Ryan (1985) in the psychological literature who found that external motivators such as monetary incentives could crowd out internal motivators such as satisfaction in the task itself.

The implication of this is that the existence of any form of economic incentive brings out the 'knavish' aspect of human nature whereas the absence of economic incentives allows

[6] '*In contriving any system of government, and fixing the several checks and controls of the constitution, every man ought to be supposed a knave and to have no other end, in all his actions, than private interest. By this interest, we must govern him and, by means of it, notwithstanding his insatiable avarice and ambition, co-operate to the public good.*' Hume (1875) pp117-18

individuals to function as altruists. Le Grand (forthcoming) investigates the evidence relating to the size of the payment required to shift the balance of motivation in voluntary and informal care sectors. He concludes that '*one set of research results suggests that market incentives devalue altruistic activities, another set that they revalue them*', but speculates that financial reward which *recognises* but does not *compensate* for self-sacrifice protects the altruistic nature of individuals' motivation.

3.1.4 Application of Economic Approaches to Social Policy

The traditional economic view of narrow individual self-interest is consistent with the Public Choice (Cullis and Jones, 1992) approach of 'methodological individualism' which argues that the public sector is run by individuals who set out to maximise their own income and operate services to serve their own interests rather than the needs of the user.

Le Grand (1997) argues that this view of incentive-driven consumers and providers has been imported into the welfare sector during the last twenty years. This is in contrast to the 1948 Beveridgean welfare state which was founded on the assumption that service providers and professionals were motivated by noble and selfless concern for people who had been placed in positions of need through no fault of their own. Introduction of market incentives into areas of welfare such as health has been interpreted as a move away from trust and altruism as a model of human motivation towards the model set out by economists (e.g. Schumpeter, 1944, and Niskanen, 1973) who reinforce the need for a market to ration resources. *'As an account of how people behave in social policy contexts, the rational choice approach has won the argument'*, claims Taylor-Gooby ruefully (1997, p98). Perhaps this is akin to Burke's (1729-1797) declaration that '*the age of chivalry is gone. That of sophisters, economists and calculators has succeeded.*' In short, self-interest is the dominant model of human motivation[7].

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[7] The dominant role of self-interest as a motivator was applied by the Conservative Government in its policy development during the period 1979-97, conveyed in the Conservative Election Manifesto, 1979, which said *'We want to work with the grain of human nature, helping people to help themselves'*. Margaret Thatcher expressed this in a controversial magazine interview which stimulated a debate about individual versus collective responsibility. *'There is no such thing as society. There are individual men and women and there are families. And no government can do anything except through people, and people must look after themselves first. It is our duty to look after ourselves and then to look after our neighbour'*, (Woman's Own, 31st October 1987, quoted in Timmins, 1995, p433). Gamble (1994) has argued that the leadership's objectives, apart from restoring the fortunes of the Conservative Party, were '*to revive market liberalism as the dominant public philosophy and to create the conditions for a free economy*'.

The Labour Government which succeeded in 1997 appears to have accepted this policy context and its implicit view of motivation by adopting market principles while simultaneously embracing a language and public spirit of partnership, involvement and co-operation. This started while in opposition when the Left redefined its economic philosophy by acknowledging the benefits of decentralised markets as a mechanism for economic decision-making in contrast to central planning through state control (e.g. Le Grand and Estrin, 1989). The new Labour Government (Department of Health, 1997) went on to signal the apparent end of competition and market principles in the NHS while retaining the underlying structure of the purchaser/provider split.

The Labour Government's attempts at building on the former Conservative policy agenda are greeted with scepticism by some who opposed Thatcherism in the 1980s. An arts review in The Observer newspaper, for

3.1.5 Selecting a Model of Individual Motivation

The psychological literature provides a model of motivation in individuals which starts from inner state, moving through to behaviour or action, orientated to a goal or incentive, the experience of which produces a modification of the inner state. This model is not integrated in the sense that any single theory unifies these elements. Rather, Steers and Porter (1991) use it as a framework to describe the areas which different theorists have sought to address. The element of the model described as 'inner state' strives towards some universality in the form of a hierarchy of needs, starting from satisfaction of basic physiological needs through to personal development or self-actualisation. In general, the psychological literature views human behaviour as goal-driven and subject to external motivation.

Managerial approaches are based on two opposing assumptions about human beings. The 'traditional' model exemplified by FW Taylor characterises individuals as mercenary and self-seeking. According to this view, incentive structures need to be put in place to goad workers towards productivity. A more recent approach to individuals, described as Neo-Human Relations, regards them as committed individuals who could be 'empowered' to shoulder responsibility in the workplace and be productive if their needs for fulfilment were properly recognised.

The traditional managerial model of individuals is consistent with the traditional economic view of *homo economicus* as a rational being in pursuit of narrow self-interest. A less popular, but still significant, counter argument within the field of economics assumes that individuals are fundamentally altruistic, as in Richard Titmuss' thesis on the motivation of blood donors. The synthesis of these two contrasting views lies in the notion that individuals can be incentivised to move from one category to another, i.e. knights can become knaves through introduction of payments for performance. Social policy since 1979 to the present leans towards the assumption that individuals will behave as *homo economicus* rather than as self-denying altruists and has favoured the application of market incentives to production and consumption, notwithstanding the current Labour Government's rhetoric concerning competition in the health service.

At the level of the individual, it is reasonable to conclude that the 'default' or dominant mode of human behaviour tends towards self-interest, reflecting the assumption which underlies theories of market behaviour and goal-driven psychological theories. This assertion makes it possible to predict how individuals will respond to incentives by analysing their impact upon personal well-being.

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example, commented that: *'[Jonathan] Miller has an abiding contempt for the batty baroness, and his production of 'The Beggar's Opera' examines the 'wolfish' individualism she encouraged. Though first performed in 1728, this underworld pastoral remains, he believes 'a most timely piece' since New Labour has cosily reconciled itself to the vulpine market forces which impel Gay's cheats and swindlers. Miller is unimpressed by the shiny Pepsodent patina of Blair.'* (The Observer Review, 21st November 1999, p5).

The 'default' supposition does not require a cynical view of human nature, nor does it deny the existence of altruism or even its status as an aspiration and desirable model of motivation[8]. Where financial incentives are in place, however, it is supposed that self-interest will calibrate human behaviour in a manner which allows us to predict how individuals will try to achieve reward.

3.2 Groups within Trusts

The sociological literature identifies which groups of individuals within Trusts are likely to be important in determining the goals and motivation of the organisation. Sociology as a discipline concerns itself with power and conflict and so, in considering Trust motivation, provides the necessary arena in which to weigh the power between potentially rival groups. Hadley and Forster (1993) highlight the difference between conventional management theory, which is based on a societal vision of regulation and stability, and sociology which stresses the importance of conflict, coercion and radical change. Like Huczynski (1993) they argue that the 'consumers' of organisational theory, i.e. trainees in management methods, may not be aware of this sociological distinction but, by their interest in perpetuating the organisation, are focused on regulation.

The sociological approach suggests that management theory, by starting from the viewpoint of the executive, confuses the actions of managers with the behaviour of the organisation. Hadley and Forster encourage the use of an action perspective which considers the viewpoints of different actors, prompting an examination of how motivational factors relate to change and conflict within organisations. It implies that at any one time the prevailing arrangements for management are likely to represent a negotiated rather than an imposed order and that renegotiation and change are intrinsic characteristics of all human institutions. They conclude that in practice power is usually wielded by a group of leaders portrayed as a coalition rather than a command hierarchy. Given that there may be other coalitions within the organisation, this directing group may be described as the *dominant coalition*.

The interaction of different interest groups can be analysed with reference to Mintzberg's (1989) key elements and coordinating mechanisms in organisations. Trusts can generally be described in terms of 'professionals' at the operating core - doctors, nurses, professional and technical staff carrying out the productive activity of the organisation; 'management' at the analytical technostructure; a combination of management and, arguably, doctors at the strategic apex; and support staff defined as ancillary, works and maintenance.

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[8] The Judeo-Christian tradition accommodates this through the Pauline distinction between grace and nature, which deems nature to be base. The struggle between mankind's natural state and the higher life of morality and enlightenment is a recurring theme of Paul's letters, e.g. *'Those who are living by their natural inclinations have their minds on the things human nature desires; those who live in the Spirit have their minds on spiritual things. ...We have no obligation to human nature to be dominated by it.'* Romans 8:5-12

3.2.1 The Role of Power

Lukes (1974) considers three views of power. The first, described as 'one-dimensional', lends itself to empirical tests since it is based on the observable outcome of decision-making. Dahl (1957) provides the point of departure through his early study 'The Concept of Power' in which his 'intuitive idea of power' is described as the ability to get another person to do something that he or she would otherwise not have done. Lukes rehearses Polsby's (1963) argument that actors' control over events can best be observed in a decision making situation, and that identifying *'who prevails in community decision-making'* seems *'the best way to determine which individuals and groups have 'more' power in social life'* (quoted in Lukes, (1974) p13*)*. The one-dimensional view of power thus focuses on behaviour in the making of decisions on issues over which there is an observable conflict of interests. The two-dimensional view extends the notion of power to 'mobilisation of bias' where *'those who benefit are placed in a preferred position to defend and promote their vested interests'* (Bachrach and Baratz, 1970, pp43-44). This typology of power embraces *'coercion, influence, authority, force and manipulation and involves both decision-making and nondecision-making, which can be observed through the allocation of benefits and privileges in the community'* (Lukes, 1974, p17). Lukes notes that the one and two dimensional views both have a common stress on actual, observable conflict since, according to Bachrach and Baratz, where there is an absence of conflict *'there is no way accurately to judge whether the thrust of a decision really is to thwart or prevent serious consideration of a demand for change that is potentially threatening to the decision-maker'* (Bachrach and Baratz, 1970, p50). A conflict of interest, according to both paradigms, is therefore necessary in order to determine who has power and where the interests of the actors lie. The three-dimensional view adds the potential for *latent* or *potential* conflict in which *'a contradiction between the interests of those exercising power and the real interests of those they exclude'* (Lukes, 1974, pp24-25) may never be actualised. The underlying concept of power shared by all three views is *'the notion that A in some way affects B'* which can be generalised *as 'the use of authoritative decisions to further collective goals'.*

This analysis provides a theoretical framework for building up hypotheses which are capable of being tested empirically. The hypotheses developed in Chapter 4 focus on two sets of actors, managers and doctors, and aim to assess their relative influence over events by attributing different sets of goals to them and then observing which goal appears to be achieved. The hypotheses are consistent with the one and two dimensional views of power in suggesting that a situation of conflict provides the best environment in which to determine which actors exert the most control.

Morgan (1996) itemises the most important sources of power, noting that these *'provide organisational members with a variety of means for enhancing their interests and resolving or perpetuating organisational conflict'* (p171). The sources of power are identified as:

1. *Formal authority*
2. *Control of scarce resources*

3. *Use of organisational structure, rules and regulations*
4. *Control of decision processes*
5. *Control of knowledge and information*
6. *Control of boundaries*
7. *Ability to cope with uncertainty*
8. *Control of technology*
9. *Interpersonal alliances, networks and control of 'informal organisation'*
10. *Control of counterorganisations*
11. *Symbolism and the management of meaning*
12. *Gender and the management of gender relations*
13. *Structural factors that define the stage of action*
14. *The power one already has.*

The sociology of the professions, considered in the next section, serves to isolate managers and doctors as the two groups which hold the main positions of power in Trusts. It is possible to argue that both groups derive power from each of the sources listed above. Empirical work is required to determine the weights of their respective sources.

3.2.2 Selecting Doctors and Managers as Power Groups

A distinctive feature of public sector organisations is their high degree of professionalisation and developments in health service structures and organisation have tended to be viewed as an attempt at curtailing the power of professionals in favour of managers.

Harrison and Pollitt (1994) argue that the main pulls following the 1991 reforms are between professionals and management since the tension between management and support staff was largely resolved through contracting out in the 1980s. They describe three strategies which have been adopted to bring health professionals into management control. '*Challenging the professionals*' was adopted with the introduction of General Management in 1984 and was accompanied by improvements in management information. Trade unions and professional associations were weakened by contracting out of support services and by the introduction of the Pay Review Bodies to replace pay negotiations in the professions. The strategy of '*incorporating the professionals*' was pursued by extensive organisational development (OD) which was intended to change the culture of organisations, to empower all staff working at the operating core and to bring doctors into management. The Resource Management Initiative (Department of Health and Social Security, 1986) was a large scale national initiative designed to achieve this through a change in the organisational structure and a development of the management information database through investment in technology. (This represents an application of the Neo Human Relations model described earlier). '*Changing the environment*' took place with the introduction of the internal market and the split between purchasers and providers and has been accompanied by an empowerment of NHS consumers.

Ferlie *et al* (1996) highlight the professional/managerial power balance as part of a central and unresolved debate within New Public Management (NPM). The definition of NPM is still being refined and, potentially, *'it includes as a central tenet a shift towards managerialism and the empowerment of management'* (p166), asking *'[i]f this empowerment has occurred, has it taken place at the expense of professionals?'* (p166). They argue that the evidence is not conclusive since *'the picture is complex and cannot simply be portrayed as a unidimensional shift of power from professionals to managers'* (p166). The functions and processes within NHS Trusts are deemed to remain essentially unchanged but the level of internal management control has increased and public sector managers are perceived to be gaining as a group. *'Even doctors can be seen as losing ground to the new cadre of General Managers in health care. However, the evidence is still slight and it is too early to conclude that this will lead remorselessly to a process of de-professionalisation'* (p7). Flynn (1992) takes the view that power has clearly shifted towards managers: *'Medical autonomy has been increasingly circumscribed by the extension of bureaucratic and managerial authority. Professional prerogatives and technical discretion are no longer taken for granted: accountability is more than ever defined in terms of corporate objectives, defined, translated and enforced by state-appointed executives'* (Flynn,1992: 183, cited in Walby and Greenwell, 1994).

The answers to the questions of power-shift are less important to this literature review than the posing of them, since they establish the tradition (e.g. Scott (1985) and Davies (1983)) that professionalisation and bureaucratisation are perceived as opposing forces. In terms of sociological and NPM perspectives on health service power structures, the relationship between professionals and managers is key to the balance of power within the NHS organisations.

Within the professional groups themselves it is necessary to consider whether a single group can be regarded as dominant. Walby and Greenwell (1994) deal with this explicitly in their examination of intraprofessional working. Nurses and doctors are identified as the two dominant professions (partly justified through their focus on acute hospital ward settings) which are considered within two competing principles of leadership. According to one principle the nurse assists the doctor in her capacity as 'handmaid', and within the other doctors and nurses belong to two complementary professions which do not form a hierarchical relationship. Historically medical consultants have had legal and organisational responsibility for patient care and from the beginning of the NHS they have been involved in managing hospitals. Medicine, therefore, is described as having a dominant position among professionals in hospitals by having authority over admissions, treatment decisions and discharge of patients. Walby and Greenwell examined the negotiated order between health professionals through subjective accounts of experience. They found that consultants' authority of treatment was evident throughout the accounts but that the balance between nurses and junior doctors was more varied. *'The essential difference in the balance of power between the two professions lies in the consultant's ultimate responsibility for the patient in hospital, and the GP's responsibility for patient treatment outside the hospital. This is*

expressed in a phrase we heard quite frequently; the consultant 'owns' the patient, an aspect of medical control that was not contested by any nurse in our study. Consultants are responsible for patients, and this sets a boundary to the extent of nursing influence within hospital. A junior doctor is moving toward this responsibility in training to become either a GP or a consultant. A nurse, however skilled, does not currently have 'ownership' of any hospital patients...' (p54).

This justifies the assumption in much of the literature that the professional/managerial contest for control in hospitals and Trusts is synonymous with a doctor/manager contest, and goes further by singling out the dominance of consultants among professionals.

The sociological literature surveyed here helps to refine the analytical framework for Trusts in that (a) it validates the view that conflicting interests may be at work simultaneously within Trusts, contrary to conventional organisational theory which assumes that managers and their decisions control the behaviour of organisations; (b) it separates professionals' interests and motivation from those of managers; (c) it distinguishes doctors from other professionals and (d) isolates consultants as being the dominant professional group, as distinct from junior doctors who jostle for positions of authority with nurses. This clarification of power groups supports the hypotheses of conflicting interests between consultants and managers which are developed in the next chapter.

3.2.3 Motivation of Doctors and Managers

The psychology literature relating to motivation of groups indicates that perhaps the most important group process is the tendency towards conformity within the group (e.g. Asch, 1958; Sherif, 1936 and the Hawthorne studies of Roethlisberger & Dickson, 1939).

Motivation of doctors as a group can be considered by referring to motivation of professionals[9]. Fincham and Rhodes (1992) note that attempts to define a set of 'traits' or qualities intrinsic to professionals and their work have never met with success. Johnson (1972), for example, has argued that claims of 'altruism' on the part of professionals were based on exaggerated accounts of their ethical role, and *'fall into the error of accepting professionals' own definitions of themselves'* (1972, p25). Fincham and Rhodes (1992) suggest that professionalism is best regarded as an occupational strategy which groups exercise to reap financial, personal and social rewards. Professional work, they contend, has three characteristics (1972, p283). Firstly there is typically a service element, meeting the needs of an individual client or contributing to the common good; secondly they are ethical occupations, which inspire a relationship of trust; and, thirdly, the professions tend to be self-regulating occupations. The trust relationship leads to a sense of altruism, lending the work an ideological character which serves the interest of the profession while professional censure

[9] Entry to the medical profession, according to Allen (1994) is determined mainly by ability and scholastic performance. Students enrol for medical degrees because they are good at science at school and select their specialty during their training on the basis of role models in medical school.

is reserved for matters of ethics rather than competence. Competence cannot be judged by outsiders since the profession conventionally monopolises knowledge through 'mystification' (1972, p286). It serves to guard the indeterminacy of its work, since codification or transparency through pursuit of best practice tends to shift control to outside managerial elements. The greater the degree of indeterminacy, combined with service, ethics and self-regulation, the higher the status and rewards available to the profession.

Activities of doctors may be described in large part as the practice of an inexact art rather than a precise science: *'the medical decision making process is a complicated interaction of scientific evidence, patient desire, doctor preferences, and all sorts of exogenous influence, some of which may be quite irrelevant'* (McPherson (1989), quoted in Culyer (1993) p169). There is evidence that some procedures have little clinical benefit, such as cholecystectomy (Gracie and Ransohoff, 1982; Bouchier, 1983; Roos and Danzinger, 1986), tonsillectomy (Roos, 1979; Paradise *et al*, 1984) and haemorrhoidectomy (The Lancet editorial, 1975). Autopsies carried out by pathologists (Cameron and McGoogan, 1981) identified that 46% of diagnoses on a sample of 1322 patients were correct prior to death, 40% were wrong and 14% had been missed. Among those who were wrongly diagnosed, 83% of patients had died of their actual condition, suggesting that a correct diagnosis could have prolonged life in some cases. Current levels of public awareness pose some challenge to the mystique and indeterminacy of medical practices. Peer review through medical audit has recently entered the public arena following the inquiry into the Bristol Infirmary heart surgeons, and wide differences revealed in practice and performance have gained prominence in the national press (e.g. The Independent, 4th November 1999).

Closure theory (Walby and Greenwell, 1994) provides insight into how the medical profession maintains its status and rewards system. 'Closure' describes the process through which an occupation controls entry to training and membership, thereby creating a monopoly over its skills and preventing others from practising the trade without recognised membership. Medicine as a profession is secured through the universities and legitimated by the state. Its institutions are well-established and influential, such as the Royal Colleges of Physicians and Surgeons, and its professional autonomy is secured through its control of clinical standards, training, recruitment and disciplinary procedures. The medical profession is underpinned by the Hippocratic ethos, guiding the doctor's relationship with the patient. The clinician has responsibilities as the patient's agent, advocate, trustee and fiduciary. Medical staff practice with autonomy, the central characteristic defining a profession (Friedson 1970), reinforcing responsibility for the individual patient while at the same time exerting occupational control (Larson, 1977). Tacit collusion between the patient body and the medical profession is highlighted by Klein (1989) who depicts medical accountability as a collective contract between the profession and the public. *'In return for control of entry, effective monopoly rights over the exercise of its skills and immunity from lay scrutiny, the profession agrees to regulate itself; as members of a profession, doctors are accountable to their peers'* (p161). He notes the view of the Merrison Committee which reported on regulation of the medical profession in 1975: *'An instructive way of looking at regulation is*

to see it as a contract between public and profession, by which the profession has made sure that it will provide satisfactory treatment' (quoted in Klein, 1989, p161).

This combination of autonomy and responsibility is not in conflict with the proposition that clinicians pursue self interest in the form of income maximisation, in keeping with public choice theorists and the notion of economic rationalism among individuals. Maximisation in the short term depends on (a) access to money (through productivity, incentives, public/private mix, contract with employer, e.g. fee per service vs. salary), (b) access to resources, in the form of hospital facilities, and (c) access to patients (Gray, 1991). These reflect the relationship between the hospital and the clinician and highlight the organisational dependence of the doctor. Income maximisation in the long term depends on (a) access to a patient base; (b) viability of the specialty, through technological and therapeutic developments, e.g. in a switch from surgery towards drugs; and (c) reputation, which has a long term impact on the patient base. Consultants' careers are characterised by a lack of mobility between specialties and a tendency towards sub-specialisation within the clinical field.

It is a matter of conjecture at this stage whether doctors' long term career objectives are dependent on their organisation, i.e. the Trust. The notion of cosmopolitan rather than local objectives (Gouldner, 1957) is consistent with doctors' autonomous behaviour and their long term dependence on the future of the specialty rather than the local organisation.

'Managers' is a generic term applied to the administrative structure of an organisation which includes '*extended hierarchies of rewards, status and power, as well as differences of occupation and function. ... Very senior managers receive rewards of money, prestige and other benefits designed to ensure that they identify closely with organisational goals*' (Fincham and Rhodes, 1992, p376). The commitment and compliance of other managers further down the organisation is less assured since the rewards and penalties for performance fall short of those going to top management.

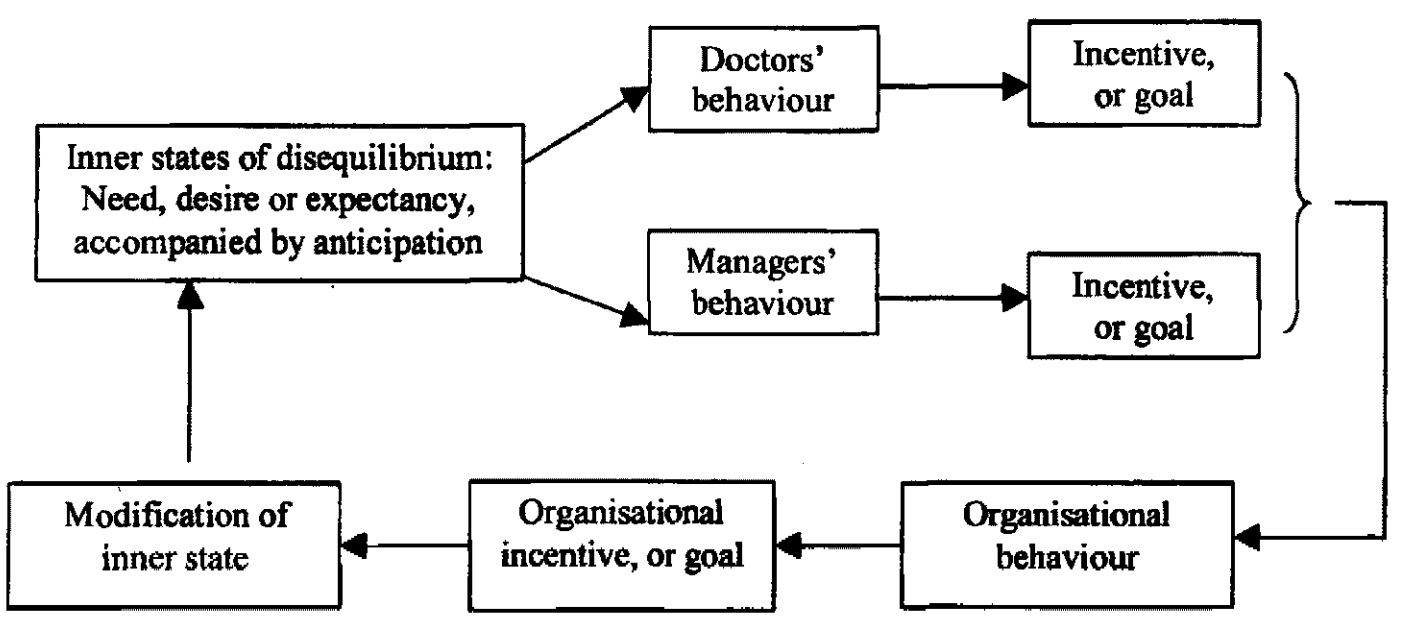
Henry Mintzberg adopts a contingency approach in examining what managers actually do and shows a substantial difference between what managers do and what they are said to do. The fragmentary nature of their activities leads to the suggestion that managers have to perform a wide variety of roles which can be grouped into three areas: interpersonal, informational and decisional. Interpersonal roles cover the relationships that a manager has to have with others, comprising three roles: figurehead, leader and liaison. They have three informational roles: monitor, disseminator and spokesman. Decision-making is regarded as the most crucial part of managerial activity and includes four roles: entrepreneur, disturbance handler, resource allocator and negotiator. Information is essential to these roles: the manager is determining the priority of information; through the interpersonal roles a manager acquires information and through the decisional roles it is put to use. The 'contingency' aspect is signalled by the manager's scope to choose a different blend of roles with the result that management is not reducible to a set of scientific statements and programmes and so

there is no solid basis for teaching a theory of management. According to Mintzberg '*the management school has been more effective at training technocrats to deal with structured problems than managers to deal with unstructured ones*' (quoted in Pugh & Hickson, 1989, p33).

3.3 Motivation of Trusts

The figure below expands Steers and Porters' generalised model of individual motivation (1991) into that of the dominant groups within Trusts and then indicates how this behaviour would manifest itself through the behaviour of the organisation.

Figure 3.3: Adapting Steers & Porters' generalised model of individual motivation to Trust organisations



Management theory implies that managers have the controlling position within organisations because of their role in co-ordinating and allocating resources. This does not, however, square with the role of the medical professional which controls resources in hospitals: *'Approximately 75% of the ongoing expenditures in health care are attributable to decisions made by physicians'* (Blumberg M, quoted in Gray, 1991, p166). The literature relating to Trusts is not conclusive in pointing to an overall dominance of either doctors or managers.

3.3.1 Trust as Organisations

Mintzberg tries to devise a way of understanding the design of organisations by defining seven main configurations: entrepreneurial, machine, professional, innovative and missionary, diversified and political. Diversified organisations are a sub-set of machine bureaucracies and political organisations tend to represent temporary phases, but the first five are considered here in more detail.

The *entrepreneurial organisation* or Simple Structure is a personal organisation in which the strongest pull is by the strategic apex towards centralisation. It has little or no technostructure, few support staff, minimal differentiation between departments, and a small

hierarchy. A top leadership, often a single individual, forms the key part of its structure which is the focus for all power and coordination, so it does not need formal planning and can be flexible and 'organic'. Many organisations start off as small-scale entrepreneurial organisations before they evolve into machine or professional bureaucracies. Examples of entrepreneurial organisations within the NHS include some general practices and the medical firm within a hospital which may be developing new treatments and promoting its work beyond the hospital's boundaries. Some people enjoy working in such an organisation because of the sense of mission it gives, and its flexibility. Others resent the domination from the top which is seen as autocratic and unfashionable. The organisation is also precarious, depending on a single individual.

The *machine organisation* is far more secure since it does not depend on one person. It is second only to the entrepreneurial organisation in centralisation, but its power is divided between the strategic apex and the technostructure which exerts the strongest pull through the planners, financial controllers, production schedulers and their kind. It fits with the definition of a bureaucratic organisation described by Max Weber (1864-1920) which has its basis in legal-rational authority, specialised, highly sub-divided work tasks, hierarchy, rules, the appointment and promotion of staff on the basis of qualifications and so on (discussed in Pugh and Hickson, 1989). The machine organisation is typically concerned with highly routinised activities and standardised products, controlled by the technostructure through formalised rules and regulations. Obvious examples of the machine organisation are mass production factories, the army and government departments. In health organisations, large hospitals usually have strongly developed machine characteristics in their administrative and nursing hierarchies. Machine bureaucracies suffer from conflict from top to bottom and between departments and, to many of the personnel, the work that they or others do appears to be meaningless.

The third kind of configuration, the *professional organisation*, is pulled by its operating core towards professionalised autonomy and so it is dominated by highly trained professional specialists. This configuration tends to emerge wherever the operating work of an enterprise is dominated by skilled workers who use procedures that are difficult to learn yet are well defined. The professional organisation is like the machine organisation in that the skills of staff are standardised, but it differs significantly in that the standards are established outside the organisation, in the training of the professionals, and that the day-to day work of the professionals requires considerable discretion. Since others without the training cannot interfere, the professionals are relatively independent and their working autonomy is usually reinforced by a high demand for the service they give. Health organisations tend to conform to the professional configuration where the professionals dominate as in general practice and in doctor-controlled hospitals. Large hospitals are likely to combine both the machine or bureaucratic elements in the administrative hierarchy and the professional and entrepreneurial elements in the medical firm, together with mixed machine-professional element of the nursing hierarchy.

The *innovative organisation* occurs where the main business of an enterprise is change and creativity and includes activities as diverse as those of fashion houses, advertising agencies and consultancy firms. It groups its highly trained specialists in project or task teams and is pulled towards co-ordination within and between teams by 'mutual adjustment', i.e. by direct co-operation, and is both organic and decentralised. Innovative organisations are not typical of health services which are primarily concerned with the provision of standard, predictable outputs. R&D sections of health organisations, however, may exhibit much in common with innovative enterprises, and these may be found within teaching hospitals and the former Special Health Authorities which have been designated as research institutions.

The *missionary organisation* emerges where the main driving force is the shared beliefs of its members, such as pressure groups and campaigning organisations. Missionary organisations are unlikely to be encountered in the public health service but voluntary organisations representing the interests of various categories of patients and some Community Health Councils will have missionary characteristics.

3.3.2 The Public Sector - Business *versus* Responsive Management

An analysis of public sector management models by Hadley and Young (1990) argues that, prior to the reforms, public services had reached a point of crisis after seven decades of stability in which they had been run according to an 'administrative model', that is to say a bureaucracy, which was *'hierarchical, rule-based, and theoretically even-handed'* (p3). The main role of public services had been to administer central and local government policies without any duty to interpret or innovate. Richard Titmuss, whose seminal work '*The Gift Relationship*' informed the analysis of individual motivation in an earlier section, was considered to be influential in creating an intellectual climate in which the state was expected to provide welfare support. He had a *'profound mistrust of the market and placed powerful emphasis in his writing on the use of the state to redistribute resources in favour of equality'* (Hadley and Hatch, 1981, p1). During the period 1961 to 1976, however, the proportion of gross national product devoted to public expenditure and social security had risen from 17% to 28% while inequalities had proved intractable. It was judged that '*the evidence from evaluations of professional interventions in education, health and social work hardly serves to explain or justify all the resources that have been devoted to them'* (p2). Hadley and Hatch commented in 1981 that *'not since the Wars of the Roses can the collective self-esteem of the English people have been at such a low ebb as it is today.'* Faith in the centralist model was being eroded from three quarters, namely (i) those which advocated use of markets to allocate resources, mainly from the radical right, (ii) 'empowerers' who promoted the voice of users as a challenge to professionals, and (iii) organisational reformers who criticised public service organisations for their lack of any clear statement of goals (Hadley and Young, 1990).

A typology of four alternatives to the administrative model has been identified, described as (i) the *residual organisation* which reduces the range of publicly provided services by returning functions to the market, (ii) the *defensive organisation* which maintains a core

collective provision through a policy of concentrating on a reduced range of services, (iii) the *business organisation* which resembles the defensive organisation but uses business methods and financial management to maintain firm central control of the organisation, and (iv) the *responsive organisation* which, like the defensive organisation, is a form of collective provision but believes that statutory organisations should be entrepreneurial, innovative and creative (Hadley and Young, 1990).

The reforms of 1991 touched on each of these lines of analysis. The creation of NHS Trusts within a market environment could be interpreted as an attempt to turn the NHS into a form of 'residual organisation'. The 1989 White Paper referred to 'self-governing' NHS Hospital Trusts, a term which was subsequently dropped from use in favour of the official nomenclature 'NHS Trusts' due to the inference that hospitals had opted out from the NHS[10]. Timmins (1995, p192) refers to a model of provision extended to NHS Trusts which was publicly funded but independently provided, in which the state used the provider as an agent. The BMA argued that the 1991 reforms *'lay the groundwork for the future dismantlement of the NHS'* (p466). Suspicions of incipient privatisation became diluted as Trust organisations rapidly became the dominant form of health care provision and their NHS publicly-funded status remained intact.

The 'business organisation' is a more obvious description of the model which NHS Trusts were intended to adhere to, given the undertaking that hospitals were to be *'reformed on business lines'* (Department of Health, 1989, p5), with an emphasis on strong financial management and efficiency. According to Hadley and Young's typology, within the business organisation *'all managers are made responsible for financial implications of their actions. Although profit is not the goal, the healthy annual balance sheet becomes as much a measure of success as in any private business'* (p17). In practice, it could be argued that Trusts continued to function as 'defensive organisations', where *collective* is synonymous with *public* provision.

The idea of a 'responsive organisation' is consistent with the notion of devolved management within a Trust through introduction of Clinical Directorates. *'The structure of the responsive service is likely to be highly decentralised and locally integrated, with extensive delegation of authority'* (p7), although in acute Trusts opportunities for integration with the local community are less apparent than for social services. This model is a challenge to the 'business organisation' since, while it is businesslike in its emphasis on clarity of goals and use of information systems, it is service-orientated and decentralist. Hadley and Young (1990) argue that the business model threatens to damage motivation of staff and runs the risk of organisational rigidity. *'A major strength of public service organisations...has been their ability to attract a significant proportion of their staff from those committed to the work of its own sake rather than primarily for the extrinsic rewards of money or status'* (p17). The potential clash between a business ethos and a service orientation comes to the fore in the

[10] *'...self-governing hospitals (later to be known as NHS Trusts as part of the massaging of language that was to occur)...'* Timmins (1995), p465

distinction between a business and a responsive organisation: *'...there would seem to be a real danger that business language and thinking will come to represent a change in goals and values rather than simply a means to achieve a better public service. In this case there would be a major risk that the commitment of many of the most effective staff would be seriously affected and that the services would lose an important part of their motive power'* (p18). Anxiety about an overweening business orientation echoes the feelings of doctors and managers which were later captured in the fieldwork enquiry. One of the practical consequences identified by Hadley and Young is that *'[t]he temptation in redefining the activities of a public organisation in business terms is to seek to detail and price every operation'* (p18).

The distinction between a business and a service orientated organisation reflected in these contrasting models goes to the heart of the tension in motivation which is addressed in the next chapter through a set of hypotheses.

3.3.3 The Economic Approach: Trusts as Firms

Economic theory treats Trusts or hospitals as firms. The firm itself has no internal structure, according to neoclassical theory (although New Institutional economists demur at this (e.g. Coase, 1937; Williamson, 1975 and 1985) and is defined by its relationship with other firms. Up until the early 1920s neoclassical theory included two main models described as pure competition and monopoly. Within these traditional models the objective of the firm is to maximise profits (based on marginal pricing) and the owner of the firm is the manager-entrepreneur; there is no separation of ownership and management.

The firm is described by a production possibilities set and it is assumed to choose the (feasible) production plan that maximises profits (Kreps, 1990), supplying output to the point where the cost of an extra unit of production is equal to the revenue gained from that unit. For hospitals this would equate to the notion that each unit of production, e.g. patient admissions, would yield additional income and that treatment would stop at the point where the cost of admitting extra patients exceeded the revenue earned. Hospitals would maximise surpluses (as a theoretical equivalent to profits) and would avoid deficits. The theory of profit maximisation is considered to be a good positive model of how firms act (Kreps, 1990) so that, even if the underlying assumptions do not resemble the way in which decisions are made in firms, the theory has credibility on the basis of its predictions. On the basis of the Darwinian principle of the survival of the fittest, it is argued that the fittest firms are those which maximise their profits. Ultimately, firms which do not maximise their profits will be driven out of business or will be taken over by other firms and the managers will be fired. Since managers do not want to be fired they will aim to maximise profits.

The neoclassical model of the firm has not been entirely supplanted by an alternative theory of equivalent analytic power and predictive ability. Nevertheless, attacks on the neoclassical assumptions are sustained and well documented (e.g. Koutsoyiannis, 1975). It is argued that

firms cannot attain the goal of profit maximisation because they do not have the necessary knowledge, information or ability. Secondly, it is argued that firms would not pursue profit maximisation, even if they could, because they do not want to. The firm may not pursue a single goal and, among the multitude of goals available, profit is only one of them. A number of alternative models of motivation have been put forward, including the following:

- *Managerialism: maximisation of the managerial utility function.* Divorce of ownership and management allows some discretion to the managers in goal-setting and factors that usually enter the managerial utility function are salaries, prestige, market share, job security, quiet life, and so on. There is no consensus among managerial theorists as to how the maximisation of the utility of managers will be attained. Baumol (1959) postulated that the managerial utility is maximised when the growth of sales revenue is maximised. Marris (1963 and 1964) suggests that the managers pursue the maximum 'balanced growth', i.e. the balanced increase of both the sales and the capital assets of the firm. If this is attained then both the utility of managers and of the owners of the firm (shareholders) is maximised.

- *Behaviourism: satisficing behaviour.* The behavioural theories of the firm started developing in the early 1950s, through Simon (1951) and then Cyert and March (1963), in which the firm is defined as a coalition of groups with conflicting interests. Goals are formed by the demands of the members of the coalition and take the form of aspiration levels. The goals of the firm are ultimately set by the top management and include five main goals of the firm: production, inventory, sales, share of the market, profit. The firm is a satisficing organisation rather than a maximiser, which is rational given the limitations of information and computational abilities of the managers, that is to say, it is 'bounded rationality'. The behavioural model of Cyert and March simulates the complexity of the mechanism of a modern multigoal, multiproduct organisation and, as such, predicts the behaviour of the firm without providing an explanation of any particular action of the firm. Behavioural theories do not deal with industry equilibrium in terms of output and price and satisficing is criticised as being tautological : whatever the firms are observed to do can be rationalised on the lines of satisficing.

- New Institutional microeconomic theory has developed the behavioural model by acknowledging internal structures and relationships within the firm. Demsetz (1991) argues that the neoclassical theory of markets in which the theory of the firm was simplified for the purpose of discussing the price mechanism has been developed at huge cost. Williamson (1991) sums up this contention: *'What was an analytically convenient theory of the firm for purposes of studying markets and equilibrium came to be treated as an adequate theory of the firm for purposes of studying economic organisation. The advantages of an all-purpose theory of the form notwithstanding, the latter was a fateful mistake'* (p10). Rather than an unindividuated agent, firms harness divergent individual objectives which are influenced through contracts, incentive structures and motivation (Putterman, 1986).

- *Long-run survival and market-share goals.* Some writers (e.g. K W Rothschild in 1947 and more recently C Handy in 1994) have suggested that the primary motive of the entrepreneur is long-run survival. Thus managers take action which aims at the maximisation of the probability that they will survive over the indefinite future. Other writers have reported that many firms set as their goal the attainment and retention of a constant market share. While this is compatible with marginalistic behaviour (MC=MR) it does not necessarily imply profit maximisation in the long-run.

- *'Full-Cost' Pricing Principle.* Hall and Hitch (1939) startled the academic community sixty years ago with a survey which suggested that firms did not attempt to maximise profits. They published results of a study of 38 'efficiently managed' firms in which they found that firms did not behave atomistically, since they were continually conscious of the reactions of their competitors, and that oligopoly was the main market structure of the business world. The study found that firms did not use the marginalist rule MC=MR and that they set their price on the basis of average cost plus a 'normal' profit of margin, usually 10%.

- *Entry-prevention and risk-avoidance.* The work of Bain (1956) and Sutton (1991) points to the possibility that the goal of the firm is to prevent new entrant firms coming into the market. Bain formulated his 'limit-price' theory in *Barriers to New Competition* in 1956 in which he drew on empirical evidence to conclude that firms take into account potential threats to entry in making their pricing decision. They set a 'limit price' which is higher than a purely competitive price but lower than a monopolistic price and is equivalent to the highest price established firms can charge without inducing entry. Barriers to entry include set-up costs in the form of initial capital requirements and the structure of the market will be determined partly by economies of scale which are a function of technology. Bain posits a one-way causation running from structure (level of concentration and barriers to entry) to conduct (degree of collusion) to performance (profitability). Sutton (1991) has developed the theory of market structure supported by empirical analysis of a matrix of industries, which takes into account exogenous sunk costs, i.e. costs of set-up and developing a product line, and endogenous sunk costs, i.e. advertising and R&D. Sutton analyses the way in which these exogenous and endogenous elements of sunk cost interact with each other in determining the equilibrium pattern of industrial structure in terms of a two stage game. At stage 1 of the game firms incur fixed outlays which are associated with acquiring a single plant of minimum efficient scale (set up costs). Entry occurs to the point at which the stage 2 profits of the last entrant cover the sunk cost incurred on entry at stage 1. High set-up costs will therefore act as a barrier to entry and Sutton's model is designed to be predictive, although he observes that there is a trade-off between the degree of predictive accuracy of a model and its breadth of application.

In summary, arguments for and against the neoclassical model of motivation which is based on profit-maximisation cannot be resolved on *a priori* grounds. The empirical evidence regarding the goals of firms is not conclusive in one direction or another but most empirical studies (Koutsoyiannis, 1975) suggest that there is a multiplicity of goals in the modern enterprise and that managers do not have unlimited discretion in setting their goals. All models accept that there is a minimum profit constraint which limits other goals of the firm.

3.3.4 Models of Hospital Conduct

McGuire (1985) surveyed the theory of hospitals and identified two main models: (a) hospitals as organisms, i.e. single entity, which is equivalent in behaviour to the atomistic firm, and (b) hospitals as models of exchange, dealing with behaviour of individuals within institutions.

Two major methodological problems are identified in the literature. The first is a difficulty in defining output and prices due to the disparate nature of hospitals (e.g. teaching, research, district general) and diversity in casemix, which leads to problems in aggregation. This implies that hospitals should be treated as specific rather than general cases. The second methodological difficulty arises in identifying the decision-making unit, where discretion of behaviour is allowed by the model. Most of the literature focuses on one actor, usually doctor or administrator (synonymous with 'manager'). Evans (1984) suggests that this may result in serious mis-specification of the model. He characterises the structure of the health care sector as one of incomplete vertical integration, which includes GPs and community services.

Introduction of the internal market in the UK in 1991 prompted researchers to look at the non-profit hospitals in the US as the nearest equivalent to NHS Trusts (e.g. Culyer, 1993; Bartlett and Le Grand, 1994). Non-profit organisations have a 'non-distribution constraint' (Hansmann, 1980) which requires the organisation to retain net surpluses to advance the service rather than distribute the earnings to controlling individuals such as board directors. Examples of nonprofits in the UK are charities, mutual societies and NHS Trusts, all of which are subject to statute which distinguishes them from profit-driven organisations such as privately owned firms or joint stock companies. Much of the US literature on nonprofits focuses on the circumstances in which nonprofits flourish in the economy (Bartlett and Le Grand, 1994) but are not explicit in stating the underlying aims of nonprofits. Newhouse (1970) considers why so few profit-making hospitals exist and concludes that, while trust between patients and doctors may inhibit profit-making enterprise, a more likely reason is that legal barriers to entry exist for profit-making hospitals and that tax subsidies provide shelter for nonprofits. Recent developments in the US healthcare industry indicate that the balance between profit and nonprofit hospitals has shifted with the growth of managed care among health maintenance organisations (HMOs). 88% of HMO enrollees belonged to non-profit plans in 1981 with 12% enrolled in for-profit HMOs. By 1989 only 54% of patients were enrolled in nonprofit HMOs and by 1999 the proportion had dropped to 36%. *'Wall*

Street loved the growth of managed care, fuelling the industry consolidation and transformation to for-profit status' (USA Today, 20th October 1999). This suggests that Newhouse was correct in attributing the financial structure of hospitals to market incentives rather than any inherent feature of the doctor-patient relationship in healthcare.

The neoclassical presumption of profit maximisation can be applied to nonprofits since profit is equivalent to surplus and varies only in its manner of distribution. Models of hospital conduct have been constructed on the basis that nonprofits will seek to maximise profits (e.g. Davis, 1972), or a combination of profit, quality and quantity (Ellis and McGuire, 1986).

A common model employed has been based on the assumption that nonprofit hospitals jointly maximise quantity and quality of service subject to a break-even constraint (e.g. Newhouse, 1970). Decision-makers, identified as the administrator appointed by the board of trustees, are perceived as trying to fulfil the hospital's social purpose by maximising the service volume and in gaining prestige for the hospital by maximising quality. This is viewed as being consistent with the motivation of medical staff who are also interested in both quality and quantity. The relative weight of quality and quantity will be negotiated between the administrator, trustees and the medical staff. This type of model implies that hospitals will minimise unit costs by producing activity beyond the optimum since the consumer, to whom the price is zero, will mediate demand through the clinician who supplies the service (moral hazard) and will seek any service with a positive perceived value while the purchaser (the insurance company) merely pays at the end (Culyer, 1993). Experience to about 1982 in the United States, when retrospective reimbursement was the norm prior to managed care, appears to confirm these predictions. Robinson and Luft (1985; 1987) found that hospitals in more competitive markets, measured by hospital density, had higher costs per patient day and per case than those in less competitive markets. Greater duplication of clinical services was found to exist in more competitive markets (Luft *et al*, 1986).

Pauly and Redisch (1973) identified clinicians as the locus of decision making within a producer co-operative with the aim of maximising income. McGuire (1985) found in general that models treating the hospital as a profit maximising entity assume that clinicians are the dominant actors whereas managerial theories predicting other forms of maximisation identify administrators as the dominant actor. The most common hypothesis is to treat the hospital as a quantity maximiser subject to a quality constraint.

In modelling hospital objectives it is not necessary to postulate maximising activity since a satisficing approach may be adopted which seeks a mixture of market share, volume output, income receipts, quality, work effort and so on.

The main problem with models of nonprofit hospital objectives is that they focus on one set of actors, either doctors or managers, and cannot deal with interdependencies. Work undertaken by Harris (1979) and Evans (1984) represents complementary approaches dealing with internal and external relationships respectively. Harris identifies medical staff and

administrators as the major actors in the organisation and emphasises that each has its own objectives, decision variables and constraints. *'The major assertion of the model is that it is the institutional constraints that arise through the medical and ethical, as distinct from the economic, motives of clinicians, that are of importance in the analysis of hospital behaviour'.* Given these non-economic considerations, '*hospitals with apparent capacity excesses or cost overrun may actually be in a deceptively stable environment'* (Harris 1979). Evans' study of the hospital as firm/industry '*suggests that analysis of the internal structure of the hospital, which is where any theory of the hospital should begin, must nevertheless take account of the effect of market structure upon behaviour, particularly with regard to how it affects the relationship between the clinician and the hospital'.*

3.4 External Environment

Beyond the logical progression from individual to group to organisation it is necessary to consider Trusts in the context of their external environment. The psychological literature justifies this on the basis of feedback and triggers which drive and reinforce performance while some areas of organisational literature deal with the 'systems perspective'. Economic theory, which uses the firm as the basic building block of analysis, focuses on the interaction of firms and consumers in the market place.

3.4.1 Reinforcement and Motivation in Environments

The psychology literature considers individuals in relation to their environments. Reinforcement theory and contingency management in organisational settings describes *how* behaviour is influenced and is used to explain how managers might achieve control rather than *what* managers do (Hamner, 1991). Learning, which results from reinforced practice or experience, is described in terms of two processes known as *classical conditioning* and *operant conditioning*. Classical conditioning was described by Pavlov (1902) who conditioned his dog to expect food upon ringing a bell, after which the dog salivated merely at the neutral stimulus of hearing the bell. Operant conditioning relates to consequences which are contingent upon the actions of the individual, e.g. passing exams is a consequence of studying while failing exams may be a consequence of not studying. Skinner (1969) indicates how interpreting the learning process enables managers to reinforce behaviour and control the workforce, e.g. through advice, warnings and commands. Reinforcement theory, e.g. Komaki, Coombs and Schepman (1991), describes the use of targets, punishments and rewards to promote performance. Cognition or learning is part of the interactive process within working environments, the analysis of which is further refined by three types of cognitive theories: equity theory, expectancy theory and social learning theory. Equity theory was developed in the 1960s (e.g. Adams and Jacobsen, 1964, Friedman and Goodman, 1967, and Lawler, Koplin, Young and Fadern, 1968) and was concerned with pay rewards and differentials. Expectancy theory, also called valence-instrumentality-expectancy (VIE) theory, supplemented the concept of equity, which was described as distributive justice, with the idea of procedural justice which focuses on how decisions to distribute particular rewards

or punishments are made (e.g. Cropanzano & Folger, 1989). The third approach to worker motivation, that of social learning, stresses the reciprocal interaction of the person, behaviour and environment. Proponents (e.g. Wood and Bandura, 1989) emphasise the importance of beliefs in one's own competencies and describe how measurement against internalised standards or goals produces motivation which is self-regulated.

3.4.2 Systems Perspective

A systems perspective seeks to identify what the controller or controllers in an organisation see as their main task and asks how they conceptualise the process of structuring and running the organisation to achieve them. The primary or survival tasks, based on three sub-systems of production, maintenance and regulation, may be defined separately from the secondary or mission tasks pursued by the organisation.

Technological demands place limits on the type of work organisation possible, but the work organisation has social and psychological properties of its own that are independent of the technology. In studies of mining, Eric Trist of the Tavistock Institute of Human Relations found that it was possible, within the same technological constraints, to operate different systems of work organisation with different social and psychological effects. This underlined the considerable degree of organisational choice available to management to enable them to take account of the social and psychological aspects (discussed in Pugh & Hickson 1989). The enterprise is conceptualised as an 'open' system because it is concerned with obtaining inputs from its environment and exporting outputs to its environment, as well as operating the conversion process in between. Environments are classified according to their degree of complexity from that of a placid, randomised environment to that of a 'turbulent field' in which significant variances arise not only from competitive organisations involved but also from the field, e.g. market, itself. This approach highlights the dynamic nature of organisations and their functioning, the crucial importance of boundary management between sub-systems, and the need for an approach to organisational design which can accommodate environmental change.

3.4.3 The Public Sector - New Public Management

Ferlie *et al* (1996) isolate public sector settings for particular scrutiny and note that, in the context of organisational analysis, there *is 'currently a dearth both of theory and of evidence'*. New Public Management (NPM) points to the reform initiatives undertaken by the post-1979 UK Conservative Government in which public sector functions became subjected to quasi-market formation, emphasis on securing VFM and stimulation of 'management of change', illustrated through appointment of high profile Chief Executive Officers to Trusts and Health Authorities. Trust Boards provided the vehicle for state-appointed non-executive directors to strengthen the apex of the organisation. Empirical data and analysis in NPM tend to be concentrated at the level of the strategic apex, focusing on health authorities (Day and Klein, 1987) and Boards (Peck and Spurgeon, 1993), justified on the basis that this strategic

tier has gained power through the post-1990 NHS reforms. Critics, however, argue that behaviour at the operational level may be unaffected by developments at this tier since the functions and processes within NHS Trusts have remained essentially unchanged.

A typology of four NPM models has been defined by Ferlie *et al*, representing a chronological development of public policy. NPM 1, The Efficiency Drive, was introduced in the early 1980s and represented an attempt to inject business values and attention to cost reduction. This was seen as a counter, appropriate or not, to the image of a wasteful public sector. The Rayner Scrutiny sought efficiency measures in the mid 1980s and resulted in an inventory of surplus accommodation identified for disposal. NPM Model 2 is characterised as downsizing and decentralisation, consistent with the development of quasi-markets and emphasis on flexible and varied systems. NPM Model 3, In Search of Excellence, is associated with best-selling texts by Tom Peters (e.g. 1982) and is slotted by Huczynski (1993) into the Guru Theory family of ideas. The bottom-up form emphasises the importance of organisational culture and acknowledges the existence of leadership in small teams or networks as well as senior managers. The critical role of medical firms to organisational change would find a place in this model. The top-down form of the model accommodates the *'coercive and transformatory reorganisations of the 1980s'* associated with the top-down vision of change, growth of logos, mission statements and uniforms. NPM Model 4, Public Service Orientation, emphasises the value of public service ideals, a scepticism about the role of markets in public services, a concern with service quality and an acknowledgement of the value of high calibre management, strengthened in part by good practice derived from the private sector. Ferlie *et al* (1996) note that this is the least well developed of the four models and has yet to reveal its full potential. Events since the change of government in 1997 lend support to this type-cast with Labour's emphasis on commitment to the NHS, education and public sector in general. The Conservative opposition subsequently appeared to embrace the public sector and lose its private market zeal, signalled by a high profile address from Peter Lilley (The Observer, 25th April 1999), lending support to NPM Model 4 as a contemporary outlook. The NHS White Paper, *'Modern . Dependable'*, (Department of Health, 1997) juxtaposes forward thinking with the notion of return to public sector values. Its major themes of breaking with the internal market and enhancing quality through clinical governance are in accordance with characteristics of NPM Model 4.

3.4.4 Market Systems

The economic view of environments is described by the theory of market systems. NHS Trusts were conceived as operating in a market setting from 1991 which became known as the 'internal market', characterised as a quasi-market (Le Grand and Bartlett, 1993). This section considers the culture and substance of market theory to establish the extent to which Trusts can be predicted to work in a given market environment.

Laws

The economist's view of markets is couched in confident language, using terms such as the 'law' of demand (e.g. Bannock, Baxter and Rees, 1978). The earliest metaphor, which remains powerful, is the concept of the *invisible hand* at work in market forces, harmonising private self-interest with the public good[11]. Its use in the eighteenth century reflected the growing conviction that scientific laws thought to be found only in nature could be found in society. Classical economists upheld the notion that natural laws are embedded in the economic process as beneficial laws, so that the automatic operation of the system is consistent with the freedom of individual action, driven by private interest, which fosters the prosperity of society.

Scientific progress in the late nineteenth century paralleled advances in neoclassical thought which perceived the world as a smoothly running machine, obeying mechanical laws of motion, in harmony and equilibrium. The view of a social world ordered according to transcendent ends was abandoned in favour of an ideal of objective knowledge of economic phenomena gained through a 'positive' study of the laws that regulate market activities.

The list of generally accepted economic laws seems to be shrinking, according to Zamagni (1989), who quoted Arrow's doubts about the mechanistically inspired understanding of economic processes : *'Is economics a subject like physics, true for all time, or are its laws historically conditioned?'* (Arrow 1985, p322). Publication of books criticising economic methodology such as Lament for Economics, a pre-war book by Barbara Wootton, The Failures of Economics by Sidney Schoeffler (1955), each noted in Blaug (1980), and The Death of Economics by Paul Ormerod (1994) demonstrate that the certainties of positive economic theorems are not universally accepted. Schoeffler argues that the entire hypothetico-deductive tradition of economic theorising is a blind alley and should effectively be scrapped and replaced by an alternative theory of rational action based on studies of decision making. Ormerod rejects orthodox economics based on rational behaviour within a mechanical, linear world of equilibrium and proffers instead the potential of non-linear systems analysis, such as chaos theory. He supports this by drawing on non-economists' studies of business and economic phenomena from a purely empirical perspective which produce inferences that may be in conflict with positive economic theory.

Notwithstanding these criticisms of economics as a science, the concept of the invisible hand has been developed into a neoclassical theory of competitive markets which has not been fully undermined and which has been influential in social policy. Theorists perceive the market system as a self-correcting mechanism which clears to achieve equilibrium. The 'marginal revolution' in the nineteenth century produced the 'Walrasian General Equilibrium' which has become central to the model of economic theory. The rational

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[11] The idea of the invisible hand originates from Bernard de Mandeville in his Fable of the Bees (1714). The metaphor itself was introduced by Adam Smith in Wealth of Nations (1776) where he asserted that every individual, acting solely in the pursuit of private gains, *is 'led by an invisible hand to promote an end which was no part of his intention'*, that end being *'the publick interest'*.

individual, *homo economicus*, is the key building block of the system and the behaviour of the economy as a whole is the summation of the behaviour of its component parts[12]. In equilibrium no individual or company can be made better off by altering the allocation of resources in any way without making at least one person worse off, a property described as the Pareto optimum. In the early 1950s Arrow, Debreu and other economists (Debreu, 1959; and Arrow and Hahn, 1971) reformulated the Walrasian system of competitive equilibrium to permit general proofs of its logical consistency and to specify the stringency of the conditions that are required to guarantee the existence of competitive equilibrium (Milgate, 1989)[13] [14].

The conditions needed to achieve perfectly competitive equilibrium are sufficiently stringent to be unlikely to hold in reality. The impact of violation of one or more of these assumptions is therefore highly significant in its implications for empirical work and has been articulated by Lipsey and Lancaster (1956-7, discussed in Winch 1971) in the 'principle of second best'. This starts from the basic premise that all conditions in the model of perfect competition need to be fulfilled if Pareto optimal equilibrium is to be achieved, i.e. a first best solution. If one condition is violated then it does not follow that a second-best solution can be achieved by fulfilling all remaining conditions. There is no corresponding set of rules for the achievement of a second-best, or even a better, position in a world where the first-best is unattainable. In practice it may be necessary to violate other conditions in order to offset the effect of the first violation.

Quasi-Markets

Quasi-markets (Le Grand and Bartlett 1993) do not fulfil the stringent criteria required for competitive markets and, by their significant divergences from conventional models, represented a new breed of markets with untested ways of behaving when they were introduced in 1991. Within quasi-markets there exists competition between suppliers, namely healthcare providers in the context of the NHS, but these organisations are not

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[12] Through the work of Alfred Marshall (1890) and Irving Fisher (1892) the concept of marginal utility was developed to account for individual consumer preferences and to draw a relationship between price and demand - the downwardly sloping demand curve. The marginal principle was applied to the firm in the law of diminishing returns, that is increasing marginal cost, to formulate the ascending supply curve. The market is in equilibrium at the price which balances these two forces of supply and demand and represents the point at which the consumer's utility and the firm's profit is maximised.

[13] Arrow-Debreu proofs of the existence of general equilibrium depend on assumptions that: (a) consumption and production sets are convex, (b) every economic agent owns some resources valued by other agents, and (c) a large or infinite number of companies and consumers exist, with no single company being able to exercise any control over the market price of its product. The global stability of such an equilibrium depends in turn on the presence of a dynamic process that guarantees that every economic agent has knowledge of the level of aggregate demand and that no final transactions are actually carried out except at equilibrium prices. For a set of prices to exist which will clear all markets it is necessary to assume that (a) the future does not exist, unless a future set of prices can be found which will clear all markets today, and (b) there is no uncertainty since consumers and producers have perfect information about the market.

[14] While the Arrow-Debreu model of general equilibrium (GE) may appear to be of only historic interest, its impact on the direction of economics has been profound: *'The widespread belief that every economic theory must be fitted into the GE mould if it is to qualify as rigorous science has perhaps been more responsible than any other intellectual force for the purely abstract and nonempirical character of so much of modern economic reasoning'* (Blaug, 1980, p193).

necessarily aiming to maximise profits. In terms of demand, consumers do not exert purchasing power directly and, instead, a purchasing agency makes choices and allocates funding to the service on behalf of the consumer.

Within the NHS internal market health care, rather than health, is the tradeable commodity. Since health itself is not tradeable it can have no value in exchange, and the demand for health and health care are not precisely related due to the lack of information on the part of the consumer or patient. The medical profession supplies this information and influences what health treatments are then demanded or utilised. The view in neoclassical economics of a sovereign consumer lying behind the demand curve is not appropriate in the market for health care due to this 'agency relationship' whereby the doctor acts as an agent on behalf of and in the interests of the patient. Effective demand for health care, i.e. demand for health care by purchasers, is exerted directly by GP Fundholders and DHAs acting as agents. Underlying this 'effective' demand are GPs and hospital consultants who induce demand through their agency relationship with the patient.

Health care is a heterogeneous commodity and also an intermediate commodity in the sense that it is not consumed for itself; moreover, its consumption *per se* involves disutility. The nature of the commodity health care can be perceived differently on the two sides of 'the market', reflecting the distinction between what is wanted (health) and what is supplied (health care). While these demand and supply perspectives differ, they tend to come together through the exercise of the agency relationship which draws on superior information on the part of the doctor to assess the costs and the benefits of the health care. Supply is the dominant side of the health care sector (McGuire, Henderson and Mooney, 1988), not least because of supplier-induced demand, where the doctor who supplies the medical intervention also determines demand for it. Klein observed this phenomenon (1989) in the paradox that the NHS '*exercises least control over those who, in theory at least, exercise the greatest influence in determining the demand for health care*'. The separation between purchaser and provider was intended to change the dynamics of demand for health care by giving commissioning agencies control over effective demand.

Financial motivation of Trusts has been identified as one of the key conditions which needs to be met to enable a market to behave efficiently (Le Grand and Bartlett, 1993). The literature review is inconclusive as to the conduct of hospitals and empirical work in this area is somewhat limited. Maximisation objectives, were they to exist, would be consistent with efficiency, where production tends towards minimum costs. McCarthy (1998) describes Trust behaviour which indicates cost-padding rather than cost-minimisation: '*Trusts are able to revise their initial prices in the light of the published district allocations - that is, to tailor their 'bid' to the funds expected*'. This is consistent with Propper's analysis (1993) of the impact of asymmetrical information between purchasers and providers. The provider has greater information than the purchaser in relation to production, e.g. inputs, technology processes and quality or outcomes. If the purchaser attempts to obtain this information and embed it into the contract, either through monitoring or as part of the bidding process, then

this will increase the transaction costs associated with the contract. If the purchaser does not seek this information then the provider will have an opportunity to pad its costs, seeking a premium within the contract which would not be paid if the purchaser had better information. Elwood (1996) stated that in contracting within two Trusts '*evidence of extensive cost-shifting and price manipulation was found. Published prices are a starting point; the overall contract value is subject to negotiation, and the providers inevitably have long-term relationships with their purchasers*' p*(viv)*. McCarthy noted that Health Authorities do not want their Trusts to go out of business and so may subsidise an overspending Trust to maintain existing levels of performance. This points to the difficulty in market exit which may influence Trust motivation by undermining any competitive or financial incentive.

There is no published work (as far as I am aware) which describes hospital or Trust motivation in dynamic terms, i.e. as influenced by the behaviour of other providers and purchasers. Theoretical models developed in the US focus on maximands which relate to profit, quantity, quality, or a combination of these factors, depending upon the locus of decision-making, i.e. administrator (manager) on behalf of the trustees or physicians (consultants). These are static equilibrium models and do not account for the impact of market structure, another condition defined as essential to the efficient operation of a quasi-market (Le Grand and Bartlett, 1993).

The US nonprofit hospital literature fails to mirror UK hospital training functions which have a direct bearing on market structure, since medical staffing and training is regulated through central planning rather than local competition. All acute hospitals which employ junior medical staff, i.e. house officers and registrars, perform a training role. Consultants have a teaching and supervisory commitment which is specified by Calman, the Chief Medical Officer, (Department of Health, 1996), and carefully monitored through accreditation processes and visits from Royal College Standards Advisory Committees (SAC). This area is centrally regulated through directives such as the New Deal on junior doctors hours, launched in December 1990 (Department of Health, 1990). The New Deal and Calman requirements work in opposite directions: Calman determines the maximum number of junior doctors in relation to consultants, e.g. one Specialist Registrar (SpR) per consultant, while the New Deal specifies the minimum number needed to ensure that junior doctors are not committed to more than 72 contracted hours[15]. In recent years there has been a substantial increase in the number of consultants nationally as a logical consequence of these pressures - if extra junior doctors are required to meet the New Deal then this will in turn create the need for more consultants to meet Calman. The overall effect of these trends will be to challenge the viability of small clinical teams, forcing hospitals into larger units. These dynamics operate without reference to competition or market forces and their impact has been made explicit in a paper by The Joint Consultants Committee of the BMA which, in conjunction with the Royal College of Physicians and Royal College of Surgeons, published a paper on

[15] 72 hours is the maximum contract for on-call rotas. The 'English' clause provides an exemption which allows doctors to have up to 83 contracted hours. 56 is the maximum for shift working, consistent with the rule that doctors spend no more than 56 hours on their feet. (National Association for Medical Personnel Specialists, 1997).

'Organisation of Acute General Hospital Services' (1999). It predicted that populations of 200,000-300,000 would continue to be served by District General Hospitals but that the 'ideal' configuration was a larger hospital with a full range of specialist services serving populations of 450-500,000[16]. Royal College recommendations on medical training indicate that '*optimum training of higher specialist trainees (SpRs) requires a concentration of hands-on experience with supervision which, in the earlier stages of training may well be achievable in a medium sized hospital, but needs to take place in larger organisational units during the later stages of specialist or subspecialist training*' (JCC, 1999, p3). Planning and non-market intervention thus continue to exert a strong influence over hospitals and need to be taken into account in any consideration of Trust objectives and constraints.

A further aspect of market structure is the ability or otherwise of Trusts to exit from the market through poor performance. The response to high market density in London, suggesting high levels of competition, was the commissioning of an *'Inquiry into London's Health Service, Medical Education and Research'* published in 1992 as the Tomlinson Report. The Government responded to the Inquiry through *'Making London Better'* (Department of Health, 1993a). While arguing that *'the internal health market should work in London, as elsewhere'* (p2), the Government's response fostered a central planning approach, arguing that *'[t]he case for action is overwhelming. Inner London has nearly 4 acute hospital beds for every 1,000 people. The national average is 2.5'* (p8). One of the recommendations (para 76, p14) called for a review of services in SW London. This review subsequently called for closure of Queen Mary's Roehampton (the consequences of which are documented as a case study in Chapter 11). The spirited and high profile campaign to prevent closure which followed was emblematic of the political barriers to exit of Trusts from the market (e.g. Turner 1994). The 1991-1997 regime stimulated competition between providers by nurturing their survival instinct, fuelling any local campaign to protect a hospital at risk of closure. The relationship between Trusts and their external environment has not been changed to any obvious extent with the more recent reforms.

3.4.5 Assessment of the External Environment

The literature relating to markets in the NHS suggests that the 1991 reforms did not establish a general competitive market (although contestability may have had an impact in specialty areas). This lack of competition could be construed as inevitable given the political resistance to Trust failure and exit from the market. Barriers to entry exist through high set-up costs (Sutton, 1991) related to capital building and equipment, in addition to medical staff

[16] Prior to the internal market, the NHS had set out standards relating to population, geographical location and access to services. The 1962 White Paper 'A Hospital Plan for England and Wales' set out normative ratios of beds per 1,000 population and established that a district general hospital of 600-800 beds should serve a population of 100,000 to 150,000. This was amended by the Bonham-Carter Committee (1969) which advised that consultant staffing mixes were better suited to DGHs covering larger populations of 300,000 or more people. It noted that travelling distance is a constraint on the size of population which can be served from one hospital. Subsequent planning solutions, (e.g. *Making London Better* (Department of Health, 1993a) which succeeded the Tomlinson Report, 1992) continued to try to balance medical staffing and education with geographical access.

training requirements which determine the specialty configuration of hospitals (JCC, July 1999).

It is reasonable to suppose that weak competitive incentives operating in the market will have influenced behaviour. Using Lipsey and Lancaster's concept of second-best solutions which are unpredictable it may also be inferred that the impact of a collapse of market-led incentives (through lack of exit) cannot be determined *a priori*. There is no theoretical construct which would allow us to predict the motivation of Trusts. The model of motivation provided by the psychological literature of inner drive, behaviour and modification through feedback (Figures 3.1 and 3.3) suggests that the experience of market behaviour will lead actors to revise their initial goals. This is consistent with a second-best solution in which compensating adjustments are needed to bring market dynamics to some form of stability or equilibrium. The evidence that hospitals are not driven 'out of business' through inefficiency and cost-overrun provides an incentive structure which could influence what consultants and managers, identified as the dominant power coalition through this review, perceive to be in their own best interests. It follows that the financial target, defined in the next chapter as a break-even constraint, would be weakened through market feedback.

3.5 Conclusion

In drawing together the data on motivation across all elements, i.e. individuals, groups, Trusts and environment, it is concluded here that:

- self-interest is the dominant motivator of individuals; this is the preferred model which aids prediction of how individuals will respond to incentives, goals and the environment;
- the individuals relevant to this study are doctors and managers which form groups or power coalitions within Trusts;
- there is little empirical or theoretical evidence to suggest how in practice the power coalitions will interact to determine the overall behaviour of Trusts;
- the market environment will send signals to doctors and managers about how they should behave; the lack of market exit is expected to weaken the financial target, and thus the financial motivation, set for and by Trusts.

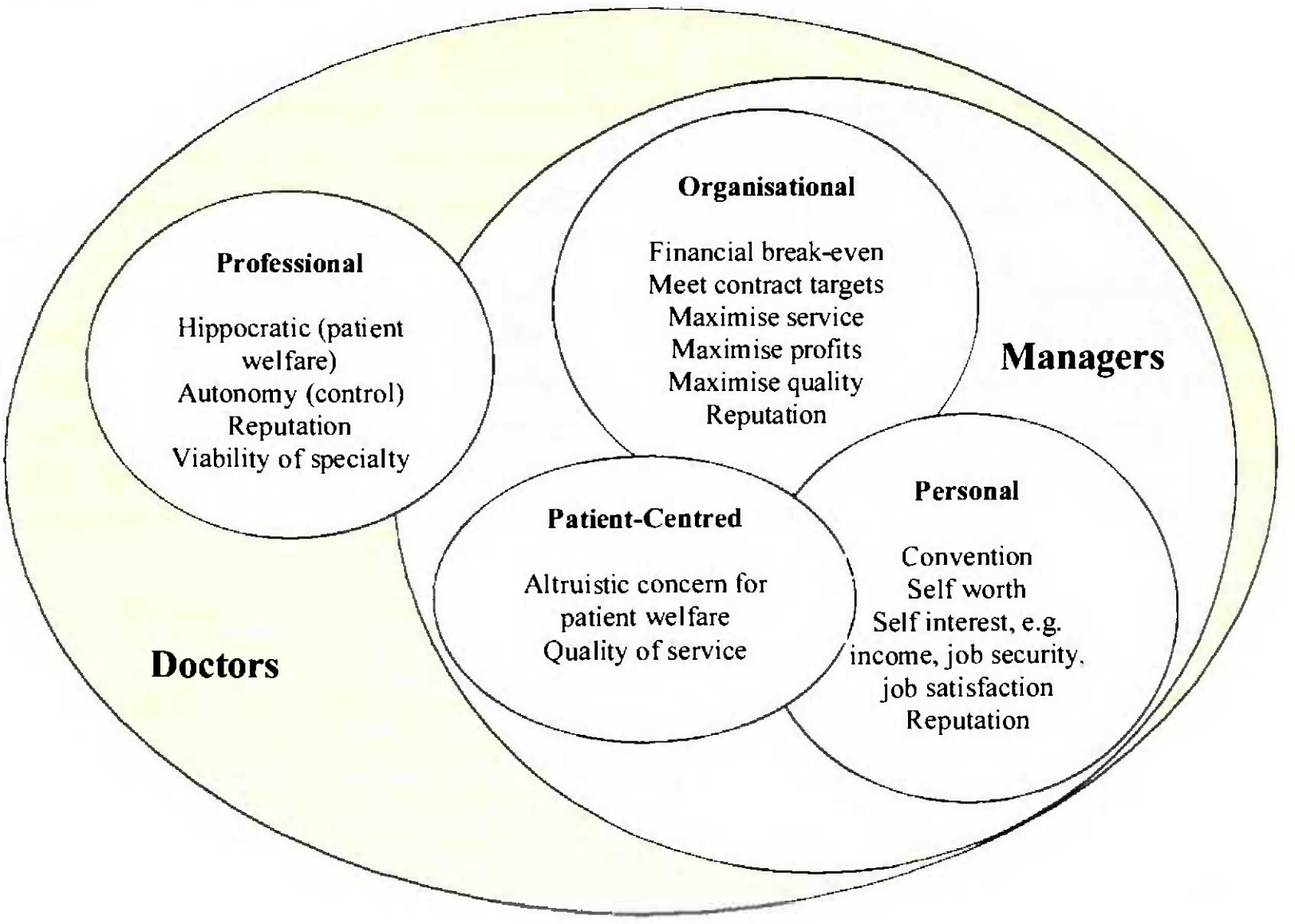
CHAPTER 4. HYPOTHESES

The conclusions of the previous chapter provide a framework for postulating objectives of individuals and how they will interact to drive Trust behaviour. This framework is used to generate a set of hypotheses which can be tested empirically in subsequent fieldwork.

4.1 Individuals' Objectives

The literature survey suggests that managers have a set of personal, organisational and patient-centred, i.e. altruistic, motivations which are interrelated. Figure 4.1 below gives examples of goals within each category and shows overlaps between the groups to indicate that one set may help to drive another, e.g. personal issues of self-worth may be linked to the aim to be altruistic and act on behalf of the patient. Some items, such as reputation, may not be unique to any particular set of goals. Managers' goals are represented as a sub-set of doctors' because, while both groups share elements of organisational, personal and patient-centred goals, doctors have an additional set of professional objectives related to their Hippocratic ethos. The literature relating to occupational control by professions suggests that in general doctors' professional goals will be consistent with their personal aims but may not always be aligned with the managerial objectives (e.g. Gouldner, 1957, discussed earlier in the context of cosmopolitan and local objectives). It is postulated here that both doctors and managers are driven by self-interest or personal goals.

Figure 4.1: Objectives of Doctors and Managers



4.2 Groups' Objectives

Taking doctors and managers as two groupings, the primary objective of self-interest is expected to be translated into different organisational objectives, depending on the incentive structure.

For clinicians, present and future earning power is linked to reputation, determining the patient base, and to the viability of the specialty. Viability in turn depends on continued development and expansion of the specialty and its ability to attract a referral base from GPs and other practitioners. In organisational terms this translates into maximisation of service (i.e. volume and quality), which is defined here as the primary objective of doctors.

Doctors' output is subject to the role of convention (Leibenstein, 1979) which slows down the pace of change from an individual consultant's existing production function to a higher function. Convention, for an individual consultant, may reflect low productivity due to limited ability or disutility of work. The hypotheses developed here relate to collective behaviour within the hospital, aggregating all performance levels. Even if doctors do not alter their personal production function, collectively they can maximise their service by increasing capacity through appointing additional consultants to the hospital and increasing the bed complement, demonstrating an expansionary instinct. They can deepen the service by applying additional radiological, diagnostic and therapeutic intervention, e.g. by using MRI scanning techniques, with the aim of increasing the quality of the service.

This objective of service maximisation is consistent with the altruistic aim of maximising patients' welfare and wins popular support among the general public. It is not, however, consistent with the restraint needed to control the public purse, which affects the electorate at large, leading to the conflict between local service demands and central funding which *Working for Patients* (Department of Health, 1989) had been designed to tackle.

Managers share the personal aims of self worth and self interest. The financial regime and the regulator's performance monitoring framework set break-even as the key measure of success for a Trust. Managers' self-interest is linked to financial break-even and so this is assumed to be the primary objective of managers. The incentive structure for senior managers, it is hypothesised therefore, is tied into the managerial goals of the organisation, the primary aim being to achieve financial balance.

The influence of the two groups, doctors and managers, can only be tested in situations of conflict, consistent with Polsby's (1963) view of power and control. Where there is no conflict it is impossible to observe which group is dominant because there is no test of their respective strength. Conditions of harmony and conflict are described in terms of 'good times' and 'bad times' as a barometer of the environment in which Trusts function.

4.2.1 Environmental Conditions - Good Times and Bad Times

Good times represent an atmosphere of prosperity in which resources via the cash limited setting of the local health economy are adequate to meet the needs of both doctors and managers. In good times revenue would be adequate to meet the cost pressures faced by the Trust without radical cost improvement programmes. Bad times, on the other hand, describe financial strictures which lead managers to alter methods of production in order to achieve financial balance. This in effect means altering the consultants' working patterns by means within the managers' control such as reducing capacity and staffing[17]. The tension between doctors and managers at this point means that their aims are likely to be in conflict.

4.2.2 Trust Objectives - Hypotheses

So far, in building up a theory of motivation, it is assumed that individuals combine into groups which face different incentive structures. These groups, doctors and managers, adopt different organisational goals in accordance with their self-interest, the relative strength of which may be tested in situations of conflict, namely 'bad times'. It is postulated here that the dominant group's objectives will drive the Trust, so that the dominant group's objective will become that of the Trust.

The groups' objectives have been summarised as budgetary or financial regulation for managers and service goals for doctors. A strong version of these premises is translated into maximisation objectives which would ideally be tested through a static equilibrium model.

Principal Actors

1. Doctors aim to maximise service (volume and quality).
2. Managers aim to work within the financial regime by meeting the break-even constraint, subject to externally imposed constraints such as waiting list targets and service volume.

Trust

3. In 'good times' these objectives will converge to form a Trust objective of service maximisation subject to a break-even constraint.
4. In 'bad times' objectives of doctors and managers will diverge. The Trust will not have a unified objective. It is hypothesised that doctors will emerge as the dominant group in the long run so that the Trust pursues service maximisation and does not achieve the break-even constraint.

Maximands, found through static equilibrium analysis (SAE), require that a relationship is modelled between a range of variables through a function or set of equations. Values for these variables would be collected on a population sample and the modelled function would be tested against the sample values by using, for example, regression analysis techniques to

[17] The extent of managers' control versus doctors' control over the means of production is explored in a questionnaire survey considered in Chapters 5-9.

yield coefficients. First and second order differentiation would be applied to identify the points in the function where profit or output is being maximised, subject to any specified constraints. To achieve robust measures it would be necessary to collect data across a large sample which is standardised to take account of predictable differences, e.g. specialty, technology, and other variations such as convention. One of the main difficulties in this sort of modelling, as McGuire observed (1985), is the problem in defining the nature of output to be measured since hospital outputs are heterogeneous in nature.

These difficulties of scale and specification have been bypassed by a reformulation of the hypotheses which considers trends rather than maximands. Trend analysis enables performance of an individual hospital to be compared from one year to the next, giving some degree of confidence that like is being compared with like, since the currency adopted by an individual hospital can be expected to have greater consistency over time than measures used by different hospitals at a single point in time[18]. Trend data can be used to test the weaker hypothesis that clinicians aim to expand rather than maximise their service in the short term. Break-even can be tested through the 6% financial target since the 6% return on assets is set to match the target break-even position for the Trust[19]. For testing purposes the hypotheses have been reformulated:

Principal Actors

1A Doctors aim to expand their service. Volume is used as a measurable proxy, but in reality service means a combination of volume and quality.

2A Managers aim to break-even, measured through the Financial Target Performance of 6% pre-interest return on assets.

Trust

3A In 'good times' these objectives will converge to form a Trust objective of service expansion subject to a break-even constraint.

4A In 'bad times' objectives of doctors and managers will diverge. The Trust will not have a unified objective. It is hypothesised that doctors will emerge as the dominant group in the long run so that the Trust pursues service expansion and does not achieve the break-even constraint.

[18] The methodology applied in Chapter 10 takes precautions to ensure like-for-like comparisons by excluding output from the maternity specialty where the measure of Finished Consultant Episodes is recognised as containing inflation from one year to the next.

[19] Annual accounts show actual income and expenditure and give a figure for operating surplus and retained surplus (after interest). The NHS Executive have flexibility to adjust interest repayments downwards if the actual operating surplus is below the target return; in other words, the Trust may show a balanced post-interest budget while failing to meet the Financial Target Performance.

4.3 Testing the Hypotheses - Methodological Approach

The logic developed in this chapter points towards three methods of testing the hypotheses by (i) conducting an attitudinal survey, (ii) undertaking a quantitative analysis and (iii) observing a case study which is used to cast light on the external pressures impinging on Trusts:

- Method 1 tests perceptions through administering a questionnaire survey to managers and doctors working within Trusts. This method focuses on the motivation of actors within the organisation by asking individuals about their own objectives and the perceived objectives of other groups. The survey tests the central hypotheses that doctors' self-interest will translate into a service quantity/quality objective within the Trust while managers' incentive structures lead them to focus on financial management.

- The interaction of these objectives and the balance of power within the organisation will manifest itself in Trust behaviour which is observable. Method 2 tests Trust objectives by analysis of financial and service performance. This quantitative study of Trust activity tests the hypothesis that doctors' objectives will tend to dominate in bad times. This test draws on the results of Method 1 to attribute behaviour of actors, i.e. doctors and managers, to overall Trust performance.

- Method 3 examines the incentive structure created by the environment through a case study which observes Trust behaviour through a sequence of events. The case study provides a test of Trust behaviour in a 'real world' setting and produces empirical evidence of external constraints which determine the level of competition operating within the environment. This is intended to complement Method 1 since, it is argued, market conditions influence the incentive structure within which doctors and managers work by providing feedback. The hypotheses are constructed on the basis that underlying self-interest will produce a set of objectives which is consistent with the existing incentive structure and which, by inference, could change with a new set of incentives.

4.3.1 Selecting the Case Study Sites

Yin (1994) emphasises the contribution of an underlying theoretical framework in selecting the structure and number of case studies. He compares single and multiple case studies and notes that multiple-case designs tend to be regarded as more robust since they offer scope for replication on the basis of similar (i.e. literal replication) or contrasting (i.e. theoretical replication) case study characteristics. The disadvantage of multiple case design is a degree of unwieldiness which sacrifices the potential depth of a single case study for the breadth of multiple case design.

This thesis uses case studies in both the questionnaire and the environmental context. The questionnaire application provides a methodological check on the sampling method adopted nationally and uses case study hospital sites A and B which offer scope for literal replication.

A and B are first wave hospital Trusts of similar size and function which are located in the south east of England and are compared through the questionnaire survey Method 1, the results of which are described in Chapter 8. The chronological case study, described in Chapter 11, uses an embedded case structure, as opposed to the self-contained holistic structure used in conjunction with the questionnaire tool. The embedded case study uses Kingston, Epsom and Queen Mary's Hospitals which operate within a local health economy extending from south west London to the M25 boundary. By exploring the chronology of events, the dynamics between Kingston and Epsom within the early years of the market reforms provide evidence about the motivation and behaviour of Trusts within a new market environment which is competitive in terms of provider-concentration. The focus of market forces throughout the period shifted to the relationship between Kingston and Queen Mary's Hospitals, and this dynamic serves to highlight the dominant forces which determine a Trust's environment and behaviour. The regulatory and political environment sets the incentive structure within which Trusts operate and which, it is postulated, has a bearing on the organisational objectives of the actors working within the Trusts.

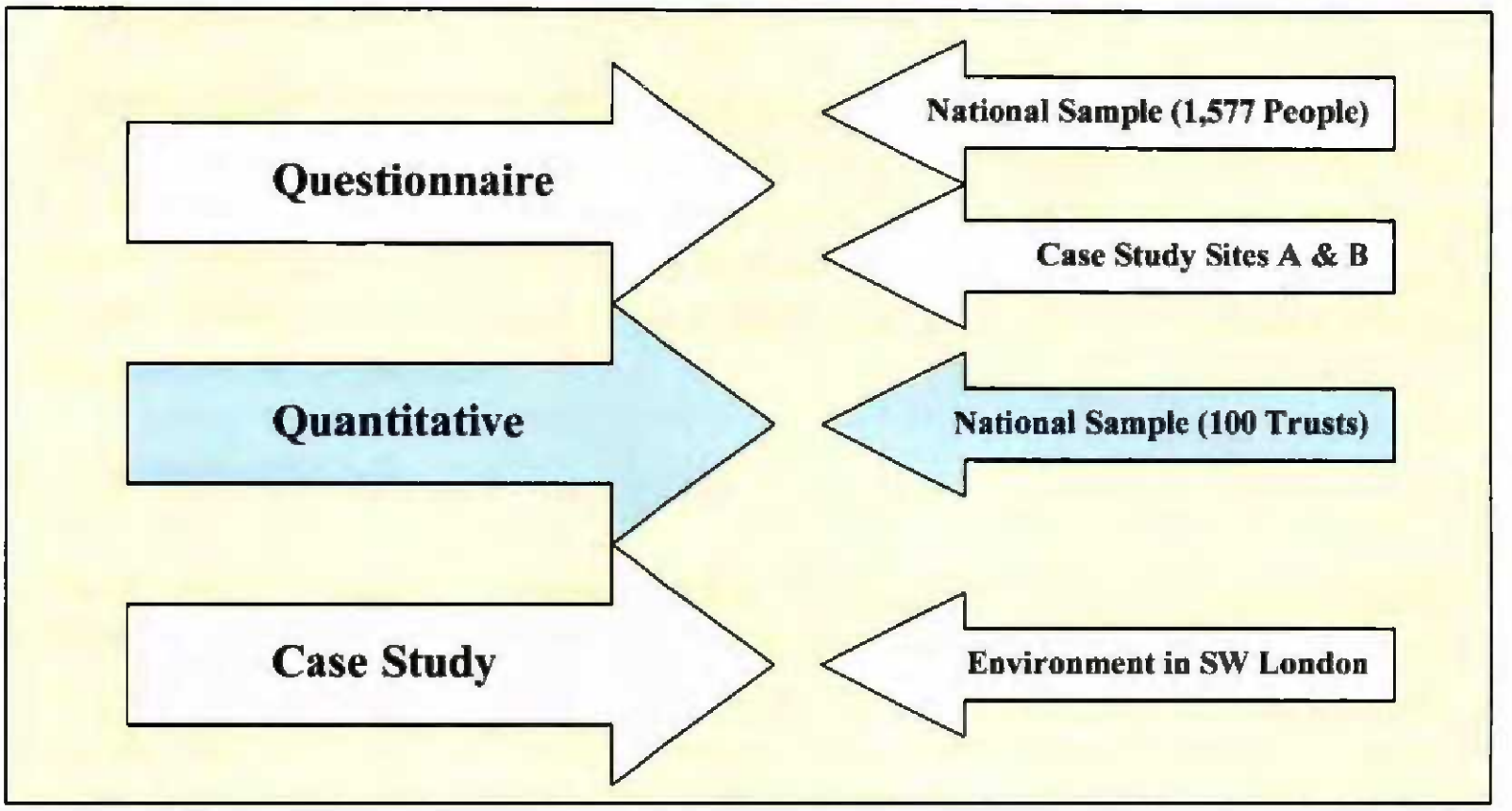
4.4 Conclusion

This thesis has developed an approach to motivation by taking individuals as the first unit of analysis and then grouping individuals into the categories of *doctors* and *managers* within the Trust as an organisation. Trusts can be considered as single entities in terms of goals and performance and they need to be observed in part through their relationship with the environment. The fieldwork enquiry has been structured to adhere to this framework:

- A questionnaire survey addresses individuals and groups within Trusts to examine what they perceive to be their own goals and what they believe to be the goals of the Trust. Hypotheses 1(A) and 2(A) correspond to this level of analysis;
- The questionnaire survey has been extended to provide a detailed sample in two Trusts, described as case study Sites A and B. The purpose of this development is to test the validity of the sampling technique used for the questionnaire survey;
- A quantitative analysis assesses the performance of Trusts. This study is designed to test Hypotheses 3(A) and 4(A), which are contingent on the first two hypotheses;
- A case study is used to examine the environment in which Trusts operate. This provides an opportunity to examine the market system which provides feedback to Trusts and, according to the psychological model of motivation depicted in Chapter 3, is likely to have an impact on the 'inner state' of motivation. In the context of this study, 'inner state' relates to the individuals and groups which drive NHS Trusts from within.

The Figure below summarises the structure of the fieldwork enquiry.

Figure 4.2: Structure of Fieldwork Enquiry



CHAPTER 5. METHODOLOGY RELATING TO QUESTIONNAIRE SURVEY

This chapter outlines the process of developing a questionnaire survey and then describes its content. The purpose of the questionnaire attitudinal survey is to explore the question 'What Drives the Trust?' and to gather evidence about Trusts' objectives through the perceptions of key players. Managers and consultants are the focus of the exercise since they represent the main power coalitions in a Trust, but the scope of the study has been extended to other professionals in the organisation.

5.1 Stages of Work

The survey was developed and executed through several stages, the first of which comprised interviews and then four pilot studies in acute and community settings. Thirteen interviews were conducted to generate an initial pilot questionnaire which was then tested in three sites. These pilots led to redesign of the questionnaire, after which it was distributed in a final extensive pilot in Hospital A. After the results of this pilot had been analysed the second stage of fieldwork was begun through a national survey which involved a mail shot to 234 Trusts across the country. The questionnaire fieldwork might have ended here with an analysis of the results. However, a comparison between the outcome of stages 1 and 2, i.e. the results of Hospital A and the national survey, prompted a third stage of work as a methodological check on the earlier work. The three stages are described in more detail below.

5.1.1 Stage 1: Development of Questionnaire: (a) Interviews, (b) Intermediate Pilots, (c) Final Pilot at Hospital A.

(a) Semi structured interviews with consultants and managers were conducted at Hospital A (also referred to as Site A in this thesis). The interview incorporated a closed list of objectives which individuals were asked to rank and discuss. The objectives were based on the hypothesis that managers would regard financial goals as the most important while consultants would be interested in service quantity and quality. It became apparent that the three financial objectives set by the NHS Executive of (i) break-even year on year, (ii) remain within External Financing Limit (EFL), and (iii) make 6% return on assets, were perceived by all except the Finance Director in terms of a single goal of break-even, understood in terms of matching expenditure to budget. The technical constraints of EFL and the 6% financial target performance were believed to be the responsibility of the Finance Director who would meet these constraints as part of the budget-setting process. As a result, the definition of financial achievement was reduced in the questionnaire to simply 'financial break-even' of expenditure against budget.

(b) A questionnaire was drafted and piloted among three Trusts (selected through the

National Association of Health Authorities and Trusts (NAHAT) which was co-operating with the study). Each pilot comprised ten individuals: (i) a community Trust piloted the questionnaire through face to face encounters in which individuals talked through their responses with the researcher; (ii) a second community Trust piloted the questionnaire which was distributed by the Chief Executive (who was interviewed initially); (iii) an acute Trust piloted the questionnaire using a mail shot via the Chief Executive's office; this acted as a pilot of the final distribution process.

The main findings of this set of pilots related to questionnaire design, sample size and participation rate. Visual presentation and question structure was refined to minimise fatigue on the part of respondents. Repetitive lists, for example, were eliminated and replaced with a single matrix and empty tick boxes were replaced by descriptive words. The participation rate ranged between 50% and 70%, even with a directive by the Chief Executive for respondents to complete the questionnaire. On this basis it was apparent that the sample size of 10 was too small to provide adequate representation by consultants since CEOs on average selected 7 managers and 3 consultants to provide a sample of 10. As a result of this trial, the national survey was designed to incorporate a pack of 20 questionnaires per Trust.

(c) A final pilot was developed and tested in Site A. This final questionnaire differed from earlier pilots in that, firstly, it was more interesting to look at and to complete - with the aim of increasing motivation and, secondly, it used a greater variety of closed question techniques, including rating, ranking and tick questions. It drew on evidence about questionnaire design which encouraged varied approaches to stimulate thought and use of descriptive words rather than numbers to rate attitudes, e.g. good, very good etc. This pilot was tested across a sample of 40 individuals, i.e. 20 managers and 20 consultants, and the results were analysed in detail.

5.1.2 Stage 2: National Survey

The questionnaire was printed under an academic banner (LSE) rather than NAHAT, which had in the meantime dissolved and transformed to become the NHS Confederation. A careful method of distribution was developed which involved (a) a phone call to the Chief Executive in two thirds of Trusts in the country (278/406 Trusts, 68%) to brief them about the study; some took the opportunity to say 'no' at this stage; (b) a batch of 20 questionnaires (or less in the case of small community Trusts) to all Trusts which did not say 'no' accompanied by a personalised covering letter and a tracking sheet to be returned to the researcher with details of participants; (c) Chief Executives were asked through this mail shot to select 10 managers and 10 consultants within the Trust and to distribute a questionnaire to each of them; the questionnaire was to be returned directly to a PO Box address set up for this survey, rather

than through the Chief Executive's office, and would therefore be confidential; a total of 4,680 questionnaires were distributed in this manner, equivalent to 241 Trusts.

124 Trusts indicated their co-operation by returning tracking sheets. By cross-referencing questionnaire batch numbers against Trusts during the analytical phase it became apparent that 143 Trusts had participated, although 19 of these Trusts had not returned a tracking sheet to the researcher to signal their involvement.

5.1.3 Stage 3: Methodological Check - Compare Hospital A with Hospital B

One notable finding from the Site A survey in Stage 1 was that managers perceived relationships and services to have improved since Trust status while consultants took a much more pessimistic view and believed that both had deteriorated. The finding was in contrast to the national survey which showed a more positive view by consultants. This could have been disregarded on the grounds that the discrepancy was due to particular characteristics within Trust A. There existed a real possibility, however, that this discrepancy could instead be highlighting a methodological problem, and so it was investigated further as Stage 3 of the questionnaire survey process.

The potential problem lay in differences in the method of selecting the consultant sample between the Site A pilot and national survey. 20 consultants at Hospital A had been selected by the researcher whereas 10 consultants in the national survey were selected by each Chief Executive. The combination of a larger sample and bypassing the CEO office at Site A means that more of the 'difficult' consultants who have a poor view of managers may have been persuaded to participate in the survey. In other Trusts CEOs would be likely to select 'friendly' consultants who have some sort of relationship with the management of the Trust. This methodological difficulty - summed up as a trade off between co-operation of CEOs and depth of consultant response - was addressed by asking a Chief Executive in Site B, which is similar to Site A in terms of size, function and market environment, to distribute 40 questionnaires and select a cross-section of 20 consultants. The similarity between the two hospitals provides a comparative case study.

5.2 Trust Selection and Numbering System

Trusts were grouped according to three types: (i) acute or whole district Trusts, (ii) community or mental health Trusts, and (iii) specialist Trusts, e.g. Birmingham Women's Hospital.

Within these groups a degree of randomness was achieved by working through an alphabetical listing. A directory of Trusts (Fitzhugh, 1997) showing the annual accounts, Trust type, CEO name and contact details provided the database from which 192 out of 213 acute/whole district Trusts were approached by telephone. 11 Trusts were omitted from this canvassing

exercise due to difficulties in accessing the Chief Executive's office. Alternate community/mental health Trusts in the alphabetical listing were selected (78/152) and one in three specialist Trusts (8/21) were approached. The process of canvassing started with a phone call to the switchboard to confirm the CEO's name. The researcher was put through to the CEO's office and then asked to speak to the Chief Executive by name. At this point the CEO's secretary was briefed about the project and undertook to obtain a response from the CEO or, in some cases, agreed to administer the questionnaire without consulting the CEO.

Less than 10% of CEO offices responded with a definite 'no'. A larger number said either 'yes', 'perhaps', asked for further details or gave no response at all. A pack of questionnaires was sent out to each of these Trusts. The majority of Trusts received 20 questionnaires but smaller Trusts (indicated by the details of the annual accounts) with turnover of approximately £15 million or less received a smaller number, set typically at 10. The size of the pack sent to these smaller Trusts was determined through discussion with the secretary to the CEO. The telephone-canvassing dates and volumes are summarised in the Figure below.

Figure 5.1: Questionnaire Administration - Telephone Calls

Out of 213 Acute/Whole District Trusts, rang:				
19/8/97	3			
20/8	26			
21/8	8			
27/8	32			
28/8	34			
9/9	37			
16/9	48			
23/9	4			
	192			
Out of 152 Community/Mental Health Trusts rang :				
(plus 20 mainly community 5th wave)				
23/9	9			
24/9	59			
25/9	10			
	78			
Out of 21 Specialist Trusts, rang:				
25/9	**8**			
Total requests:	**278**	out of	406	*68%*

Each questionnaire was printed with a four digit number starting at 1001. Trust types were allocated blocks of numbers, to assist in subsequent analysis. Packs of questionnaires

consecutively numbered were sent to each Trust contact point together with a personalised covering letter containing instructions for circulation and a tracking sheet. The instructions were simple, inviting the CEO to select 10 managers and 10 consultants within the Trust and to circulate a questionnaire to each of them. The tracking sheets contained a list of the questionnaire numbers supplied to the Trust and a request to the person administering the survey to return this sheet together with the names and an indication of consultant/manager status. The purpose of this tracking sheet was to exert a degree of discipline over the distribution process. The consultant/manager indicator proved to be useful at the data input stage when individuals had failed to identify their status within the organisation. It was also intended to provide an audit trail to enable the researcher to chase respondents via the CEO's office if required although, in the event, the response rate was sufficiently high within the large sample to render this audit trail unnecessary. The tracking sheet contained the name and contact detail of the individual administering the survey locally. This added to the audit trail but its main function was to raise the level of personal accountability locally and therefore to enhance the quality of the administrative process. The volume and numbering system of the questionnaires distributed are summarised below.

Figure 5.2: Questionnaire Administration - Mail Shots

SENT OUT LETTERS & PACKS						
3/9/97	4					
4/9	47					
9/9	35					
12/9	20					
22/9	44					
23/9	14					
24/9	31					
25/9	46					
	241	PLUS 9 SINGLE LETTERS AND 7 FAXES				
TOTAL QUESTIONNAIRES SENT OUT:						
ACUTE/WHOLE DISTRICT						
NUMBERS						
1001 - 4400	3400	170	packs of twenty			
COMMUNITY/MENTAL HEALTH						
4501-5640	1140	63	average of	18	per pack	
SPECIALIST						
5801-5940	140					
TOTAL QUESTIONNAIRES SENT OUT						
	4680					

5.3 Scale and Production of Questionnaire

The questionnaire was designed to cover four sides of A4. This was determined on the basis of printing and production requirements and with reference to the need to maximise the response rate by making the questionnaire attractive and succinct. Appendix 1 includes the questionnaire, printed on a folded A3 sheet, and shows that the front page contained a briefing to the individual, together with details of the return address. The pilot testing stage had been used to ascertain an average duration for completing the questionnaire. This average of approximately 10 minutes was included in the briefing details in order to gain commitment from the respondent. A PO Box return address was established for ease of administration and to add to the credibility of the questionnaire, in preference to a personal reply address. The pilot tests had been performed under cover of the National Association of Health Authorities and Trusts (NAHAT). Due to the subsequent dismantling of this organisation and merger with the NHS Trust Federation to become the NHS Confederation, the option to use the NAHAT logo and endorsement was no longer available. Authority was received to use the LSE logo on the questionnaire and to send the pack out under cover of LSE notepaper.

5.4 Target Respondents

Within the questionnaire itself respondents were encouraged to describe themselves according to one or more categories to capture clinical and management aspects of individuals' roles:

Figure 5.3: Question 'You Are...?'

You are *(please tick all boxes which apply to you)*:

- ☐ CEO
- ☐ Chairman
- ☐ Board Director
- ☐ Consultant - Chair of Clinical Directorate
- ☐ Consultant
- ☐ Clinical Professional (non-medical)
- ☐ Corporate Manager_____
- ☐ Service/Business Manager (inc clinician)
- ☐ Other _____

These responses were used to categorise doctors and managers across 11 separate and unique groups set out in the Figure below.

Figure 5.4: Respondent Groups

	Category
Consultants	1. *Chair Clinical Directorates*
	2. *Board Director*
	3. *Consultants Only*
Managers	4. *Chair*
	5. *CEO*
	6. *Board Director*
	7. *Corporate*
	8. *Clinical Professional*
	9. *Service/Business Manager*
	10. *Other Manager*
	11. *Unidentified*

5.5 Statistical Methods

The questionnaire was coded in advance for data input and analysis. A code was attributed to each possible response within closed questions. Open questions were coded before data input on the basis of transcripts from one third of the sample which responded. The coding structure allowed data to be aggregated to derive frequency of responses according to characteristics of the respondents. The *manager/consultant* grouping was an important level of disaggregation, essential in testing the hypotheses.

5.5.1 Use of Mean Value

The mean value is a convenient measure for handling both rating and ranking scores and observing central tendencies of the results. Results were summarised into mean scores to provide an initial account of doctors' and managers' responses. Further tests were applied to check whether differences between mean scores could be regarded as significant. These tests were applied at Stage 2 of the programme, i.e. to the national sample of questionnaires.

5.5.2 ANOVA

The test most commonly employed was a comparison of mean scores using ANOVA (One Way Analysis of Variance). The SPSS Definition of One Way ANOVA is : *This procedure tests the null hypothesis that data is a sample from a population in which the mean of a test variable is equal in several independent groups of cases defined by a single grouping variable.* The single grouping variable in this questionnaire survey is generally 'who', i.e. whether the respondent is a doctor or a manager or a subset of either group.

5.6 Question 1. To what extent does your career depend on the following factors?

The purpose of this question was to establish the difference in personal motivation between doctors and managers, testing the hypothesis that:

- organisational goals are of less importance to doctors than their wider professional aims, i.e. the survival of the clinical specialty is of greater importance to a doctor's career than survival of the organisation;
- the opposite is true for managers: survival of the organisation is very important since organisational boundaries define managers' careers. The organisational objectives of the Trust will therefore carry more weight with managers than with consultants.

5.6.1 Question Structure and Coding System

Respondents were asked to rate the importance of the eight factors (plus *other...*) below to their own careers, on a five point scale which was set at 5 intuitively regular intervals: very low, low, moderate, high, very high. Individuals circled the word(s) which applied and this set of responses was subsequently translated into a 1 - 5 rating scale for quantitative analysis.

1a A financially successful Trust
1b Success of your specialty /dept. within the Trust
1c Strength of your specialty/profession nationally

1d Individual reputation
1e Reputation of Trust/hospital
1f Standard of R&D or teaching

1g Survival of the Trust as an organisation
1h Continued provision of the Trust's clinical service
1j Other (specify) .....

Enquiries about income maximisation and private patients were considered to be too invasive to include in a postal questionnaire and so this factor was omitted, although it was explored during the developmental phase.

5.6.2 Method of Analysis

Doctors and managers were grouped into two categories and the null hypothesis that their responses were drawn from the same population was tested at the 5% and the 1% level of confidence using the ANOVA technique. The test was repeated within doctors (categories 1-3) and managers (categories 4-9) and then across all categories (1-9)[20]. The difference within the manager group was explored by considering a range of groupings.

[20] In this case categories 10 (other managers) and 11 (unknown) were omitted, even though the questionnaire descriptions indicated that most managers in category 10 would probably belong to category 9 (service/business managers); groups 10 and 11 are omitted on the basis of their small size in relation to other categories.

The use of mean rating scores could be criticised on the grounds that the ratings are strictly ordinal rather than interval measures and so should be examined through non-parametric tests. Chi-squared analysis of frequency distributions is used to test whether the distribution of rating scores is significantly different between samples (where the null hypothesis assumes no difference between the sample populations). The differences between groups of respondents has been tested in two ways: (i) retaining the eleven different groupings (where 'unknown' is the eleventh group), and (ii) by grouping doctors and managers into two categories.

5.7 Question 2. Within the Trust, how would you rank the priorities for the following sets of people?

This question is the most important within the questionnaire. The aim was to elicit individuals' perceptions of their own priorities and to find out what they thought about other groups. They were asked to rank their own priorities and those of most business/service managers, most consultants, the Trust now and the Trust ideally. The question has been structured to separate consultants as a group from managers in order to test the hypotheses of differences between them.

5.7.1 Question Structure and Coding System

'The Trust' has been identified as a separate entity in the question to give respondents the opportunity to make an objective assessment of the organisation's goals and to test the extent to which these goals can be aligned to those of individuals. The question structure is motivated by the possibility that neither doctors nor managers identify with the Trust as an organisation. Should this be the case then, given the powerful position of these two groups, its implications would need to be considered in terms of control over Trust performance.

5.7.2 Method of Analysis

Respondents were grouped into two categories (1) Doctors (Groups 1-3) and (2) Managers (Groups 4-11). They were asked to rank objectives (set out in the Figure below) in order of priority 1-7. This is an ordinal variable but some insight has been gained into the data by summarising the rankings into mean values[21]. One-Way-ANOVA has been used to compare the mean rankings for each variable, e.g. ***2a break even-financially,*** between the two groups. A non parametric test, two-tailed Mann-Whitney U, was also applied to test whether doctors and managers form two independent samples. This test observes the ranking frequencies between the two groups. It is a non parametric alternative to the *t* test, requiring at least an ordinal level of measurement, and uses the ranks of the cases to calculate U.

[21]Oppenheimer comments: *'In strict measurement terms this is wrong, and it follows that the parametric techniques for statistical analysis are not applicable. Yet researchers frequently take liberties with the requirements and assumptions upon which these statistical techniques are based in the hope that the techniques will prove sufficiently robust to withstand a certain amount of abuse, and that the ensuing results and conclusions will not be too misleading'*. A. N Oppenheimer (1992) p158

The set of respondents was restored to eleven separate categories of individuals and ANOVA and Kruskal-Wallis H tests were applied. The Kruskal Wallis H test is a non-parametric alternative to One Way ANOVA. It tests whether several independent samples come from the same population. It assumes that the underlying variable has a continuous distribution and requires at least an ordinal level of measurement. The results of Kruskal-Wallis were used as a cross-check against the validity of the ANOVA test, thus testing the assumption of a normal distribution of means.

Figure 5.5: Question 2 Structure

Q2. Within the Trust, how would you rank the priorities for the following sets of people?
This question asks for the order of priorities which, in your view, is held by these groups.
For each column please rank priorities in order 1, 2, 3 etc where 1 is the most important.
*If you tie values, then please adjust rankings, e.g. 1,2,**3,3,5**,6.*

	You	Most Business & Service Managers	Most Consultants	The Trust Now	The Trust Ideally
Break-even financially	2a	2h	2r	2y	2af
Maintain service volume *You may tie these if you wish*	2b	2j	2s	2z	2ag
Maintain service quality	2c	2k	2t	2aa	2ah
Expand revenue	2d	2m	2u	2ab	2aj
Expand service volume *You may tie these if you wish*	2e	2n	2v	2ac	2ak
Expand service quality	2f	2p	2w	2ad	2am
Other (please specify) e.g. innovation, teaching, R&D	2g	2q	2x	2ae	2an

5.8 Question 3. Which body is achieving its main objective?

3a) Which Body is Achieving its Main Objective Now?
3b) Which Body will Achieve its Main Objective During the Next Three Years?
3c) Which Body will Achieve its Main Objective During the Next Six Years?

Individuals were asked to place a tick against which body they believed was achieving its

main objective at the moment and which was likely to achieve it in the medium and longer term. Respondents were allowed to tick more than one from a choice of *Managers*, *Consultants*, *Trust* and *None*. This was an impressionistic question designed to reflect the general outlook of managers and consultants and to give a sense of which element of the organisation was considered to be dominant. A descriptive account of the frequency of responses was used to indicate how doctors and managers viewed the balance of power.

5.9 Question 4. How have priorities changed since the organisation became a Trust ?

Respondents were asked to rate how their own priorities had changed since Trust status and were asked to take a view on how the Trust priorities had changed during the same period. The description of priorities followed a similar pattern to that used earlier in Question 2, but these were collapsed into fewer objectives and two different ones were inserted: 'be responsive to patients', 'be responsive to GPs'. The main purpose of the restructuring was to avoid fatigue and boredom through repetition on the part of the respondent and also to glean additional information. Respondents were asked to circle words and, for purposes of analysis, these were coded at intervals where 1=weaker, 2=no change, 3=stronger.

On a three scale rating the use of the mean as a measure of central tendency overloads the scores in terms of importance. Nevertheless, two tests were used against this ratings distribution to assess whether doctors and managers responded as independent groups, i.e. *ANOVA* and *Pearson Chi Square*. Descriptive statistics in terms of frequency distribution of responses provide a clearer picture about the balance of responses.

5.10 Question 5a. Since the change to Trust status, how has the relationship changed between consultants and managers?

Consultants and managers were asked to rate whether they thought the relationship between the two groups had deteriorated or improved over the period. This question and, likewise, Question 6a was included at the request of the Chairman of NAHAT in response to a request for NAHAT endorsement of the questionnaire. Respondents were asked to circle words and, as in Question 5, were coded at the analytical stage at equal intervals where 1=much worse, 2=worse, 3=no change, 4 = better, 5 = much better.

ANOVA tests of independence were conducted to test the response patterns of a range of groupings, starting with the two groups comprising doctors and managers and then exploring the similarity or otherwise of sub-groups within doctors and sub-groups within managers. A descriptive account of the ratings distribution was also produced.

5.11 Question 5b. Why has the relationship changed between consultants and managers?

After the rating exercise consultants and managers were given the opportunity to comment on their perception of consultant/manager relationships. The open question allowed them to explain the reasons for change.

A coding system was devised on the basis of a large sample of the open question responses. One third of responses were transcribed and printed for review. This text was used to devise a thirteen code structure at ten point intervals, e.g. 10, 20 .... 130. The purpose of the intervals was to enable sub-division within these codes, e.g. 80, 81. The final presentation of responses was collapsed to 11 coding groups. Where several responses were provided, a code was applied to the primary response.

5.12 Question 6a. Since the change to Trust status, how has the service to patients changed?

Consultants and managers were asked to rate whether they thought the service to patients had deteriorated or improved over the period. Respondents were asked to circle words which were coded subsequently using equi-distant intervals of 1=much worse, 2=worse, 3=no change, 4 = better, 5 = much better.

ANOVA tests of independence were conducted according to the same structure used to analyse Question 5a. Likewise, a descriptive account of the ratings distribution was produced.

5.13 Question 6b. Why have services to patients changed ?

Respondents were given the opportunity to explain why they thought services to patients had changed since Trust status through an open question 'Why?'. A coding system was devised on the basis of a large sample of the open question responses. One third of responses were transcribed and printed for review. This text was used to devise an eight code structure at mainly ten point intervals, e.g. 10, 20 .... 70, 99. Sub-division within these codes was applied as required. As in question 5b, where several responses were provided, a code was applied to the primary response.

5.14 Question 7. Since the change to Trust status, do you think the goals of consultants have .....?

Moved closer together ***Not changed*** ***Moved further apart***

Question 2 asked about current goals and Question 5 asked about the relationship between

doctors and managers. Notwithstanding the existing state of goals and relationships, this question enquired whether there had been any movement over time. Rating scales were applied for coding purposes, using 1 = Moved closer together, 2 = Not changed, 3 = Moved further apart. A battery of ANOVA tests was applied using the same structure as in Questions 6a and 5a. Frequency distributions provided a descriptive account of responses.

5.15 Question 8. Which group, in your view, has the most control over the following aspects of service?

(a) *Development of service*
(b) *Availability of facilities (e.g. beds, theatres)*
(c) *Medical staffing levels*
(d) *Nurse staffing levels*
(e) *Freedom to admit in-patients*
(f) *Decision to treat patient*

The purpose of this question was to examine people's perception of power in terms of control of activities and resources. The resource inputs to a hospital include the facilities or fixed assets which include beds and operating theatres, together with staffing - regarded as a semi-fixed cost (Department of Health, 1993b), and variable costs or consumables. Variable costs comprise only 10% of the cost of treating each patient whereas staffing comprises 70%. The availability of facilities is a function of the capital capacity of the hospital and the workforce needed to staff beds and other elements of service.

Earlier questions dealt with perceptions of motivation (Question 2 regarding priorities) and achievement of objectives (Question 3). Power to meet service objectives or budgetary goals, however, is predicated on the ability to control resources within the Trust. It has been argued that doctors control the major part of resource allocation within hospitals and it was this feature combined with doctors' locus outside the management culture which stimulated the Resource Management Initiative (RMI) 1986-1994 (Department of Health, 1986). Resource Management was aimed at achieving better use of resources by (a) involving clinicians in decision making processes, (b) providing clinicians and managers with the information needed to support their roles, and (c) devolving accountability to the level in the organisation closest to the point of service delivery. The introduction of *Working for Patients* (Department of Health, 1989) and Trust status coincided with the roll-out of RMI. Many of the features subsequently addressed in Question 5b, e.g. clinicians in management, had therefore been piloted and developed in the NHS prior to 1991 but were reinforced by the White Paper reforms since, in order to achieve Trust status, organisations were obliged to reform the management structure to demonstrate clinical involvement. This in effect meant that directorate structures were an essential component of applications for NHS Trust status.

Question 8 seeks to draw a profile of who controls resources and activities, or who is perceived to control them, as a cross-check on managers' and doctors' ability to determine the

destiny of the organisation. (The results could have some relevance in assembling a model of hospital production functions in a separate piece of work).

Approximately 10% of respondents selected more than one item in response to each question. The results were therefore input as a count and displayed as a frequency distribution across the doctor and manager categories.

5.16 Question 9. Do you think the NHS climate will change with the new government?
& Question 10a. Would you welcome change in the future?

This question was inserted to add topicality to the questionnaire since the study was administered in the autumn of 1997 in the knowledge that the recently elected Labour Government was about to publish its policy intentions through a White Paper, finally issued at the beginning of December 1997 (Department of Health, 1997). An enquiry about the appetite for change was intended to add an extra dimension to the earlier question about changes in services and working relationships. If doctors and managers had proved to be either positive or negative in their views about changes since Trust status then further insight could be provided through linking this to their view of the future.

5.17 Question 10b and 10c. Why would you welcome change in the future and what sort of change would you like?

Respondents were given the opportunity to comment on their attitude to change and to explain the sort of change they would like through an open question. The blank space allocated to this question was more than 4" in length, which is large by comparison to other response areas. As the final question in the series it was intended to provide a soap-box for respondents who had a strong desire to express their views, adding to the depth of their overall response. It also gave space to collect a large volume of observations.

One third of responses were transcribed in full and printed. A coding system was devised on the basis of this large sample in which every item was coded. If a respondent set out four separate suggestions, for example, these were allocated four codes. 10 major categories were identified using codes 10, 20 .... 100. These were further subdivided and, due to the range of observations, it was necessary to use alpha codes *a, b, ...* to extend the number of sub-groups to ten-plus.

CHAPTER 6. QUESTIONNAIRE SURVEY: RESULTS OF STAGE 1

This chapter brings together the results of the first stage of the questionnaire survey. It focuses on the response to the final pilot survey at Hospital A but also brings in data from the developmental part of this stage which used face to face interviews to begin to design the questionnaire. This approach is possible because Hospital A was used both at this developmental stage and then, after a series of intermediate pilots, in testing the final questionnaire pilot.

6.1 Response Rate and Sample Description

The Hospital A survey was distributed to 40 individuals, selected by the researcher, 17 (43%) of whom were consultants and 23 (57%) of whom were managers. The overall response was 55% (22/40), comprising 9 (41%) consultants and 13 (59%) managers. Respondents were encouraged to describe themselves within one or more categories in order to capture clinical and management aspects of their roles. The respondent set is summarised in the table below.

Table 6.1: Set of Respondents

Hospital A Respondents		Category
18.2%	4	1. Chair Clinical Directorates
0.0%	0	2. Board Director
22.7%	5	3. Consultants Only
40.9%	**9**	**Total Consultants**
0.0%	0	4. Chair
4.5%	1	5. CEO
4.5%	1	6. Board Director
22.7%	5	7. Corporate
4.5%	1	8. Clinical Professional
18.2%	4	9. Service/Business Manager
4.5%	1	10. Other Manager
0.0%	0	11. Unidentified
59.1%	**13**	**Total Managers**
100.0%	22	
63%		% Management Time

6.2 Question 1. To what extent does your career depend on the following factors?

Consistent with the concept of cosmopolitan boundaries at work within professions, *1g) survival of the Trust as an organisation* was markedly more important to managers than to

doctors. Only two other areas showed significant differences between the disciplines: *1c) strength of the specialty/profession nationally* which, as one would expect, is more widely supported by doctors and *1f) Standard of R&D and Teaching* to which again doctors award greater importance. *Personal reputation* was considered to be of equal importance by both groups.

Table 6.2: Mean Rating Scores on a Scale 1-5 where 1 is very low and 5 is very high

Hospital A	**1a**	**1b**	**1c**	**1d**	**1e**	**1f**	**1g**	**1h**	**1j**
Total Sample - Mean	3.3	3.95	3.2	4.52	3.86	2.95	3.77	4.18	3.5
Doctors Sample - Mean	3.38	3.75	3.75	4.44	3.89	3.78	3.22	4.44	4
Managers Sample - Mean	3.25	4.08	2.83	4.58	3.85	2.27	4.15	4	
Point Difference: Doctors - Managers	*0.13*	*-0.33*	*0.92*	*-0.14*	*0.04*	*1.51*	*-0.93*	*0.44*	*4*

As the first question in the sample, Question 1 was designed to be simple to fill in and to shed some light on the personal motivation of managers and consultants in terms of their career. The issue of personal income and private practice was not included in the questionnaire on the grounds that consultants might resent the intrusion, but this was explored during Stage 1 through interviews with three surgical consultants, all of whom were candid about the importance of private practice.

One clinician disclosed that for just over one private day a week he earned £100,000 per annum, thereby more than doubling his NHS salary. The choice between NHS and private work is not clear cut since private work comes in through the NHS umbrella; GPs refer patients via outpatients and private insurance covers for inpatient treatment. *'If a consultant went purely private he would lose that source of referral. The stream of patients needs to be kept alive'.* As for consultants' primary objective, the same clinician observed *'First of all, consultants want the NHS to survive, because if it didn't they wouldn't get private practice.'* In considering whether doctors, unlike managers, were motivated by altruism he was frank in his remark that *'No, most surgeons are primarily interested in running a private practice.'*

A second consultant argued that consultants are more concerned about their NHS work than their private work, but conceded that his personal finances depended on private income: *'Consultants first of all want to make a success of their job and then build up their private practice. I would love to do all my work in the NHS - I could be so much more efficient, instead of running round to 6 different places; the majority of doctors want to organise their service efficiently. I couldn't afford to give up private work with my commitments - I still have two daughters whose education needs to be paid for. I earn about £300k a year which dwarfs my consultant salary.'* A third consultant responded in similar vein: *'If I am forced to make a choice I must choose the private practice. I can't afford to do anything else. Doctors in the NHS are grossly underpaid.'*

There was a common view among surgeons that the NHS would benefit by insisting that

consultants performed their private practice on the NHS hospital site: *'Private practice is fine as long as you do the NHS work. Barbara Castle screwed it up. She should have made all doctors stay on site to do private work. You know where they are then and they are always available if problems arise.'*

The reasons for entering medicine as a career were touched upon and the consultants indicated that enjoyment of the work and environment was important: *'Working as a hospital doctor is fine, until you get hassle. There is a lot more hassle now.' 'I enjoy it. I like eyes and I am fascinated by ophthalmic surgery.'* One started to describe how his approach had mellowed but went on to display the vigour with which consultants maintain their autonomy and control resources: *'I don't often get het up nowadays. Although on Friday I got angry with J [a fellow consultant with responsibility for the Day Surgery Unit]. He has become terribly pompous, terribly pompous. I brought a patient into the Day Surgery Unit who needed to be admitted as an inpatient. J told me she couldn't be treated in the DSU and we had a fight on the phone. Of course I treated her. Luckily J was ringing from the L [private hospital down the road] and couldn't come and stop me.'* General motivation of clinicians was summed up by a consultant quite simply: *'Doctors are a pain in the neck. They behave badly. Their main aim is their own self interest, so they can be obstructive. Self-interest isn't necessarily financial, and in most cases is not. In general doctors don't want hassle. They want to work in good units and don't want them to be made worse. They want good working conditions.'* This, it was felt, bred medical intransigence in the face of change and, specifically, meant that clinicians would be reluctant to merge services with unfamiliar colleagues at neighbouring hospitals.

6.3 Question 2. Within the Trust, how would you rank the priorities for the following sets of people?

A closed set of objectives was defined after discussion with 13 managers and clinicians at Hospital A. The aim was to elicit individuals' perceptions of their own priorities and to find out what they thought about other groups. The table which follows summarises perceptions by calculating the mean ranking for each priority.

Table 6.3: Summary of Question 2 Responses

Q2	Priorities Perceived as Belonging to :	Objective	Doctors Mean	Managers Mean	Difference	Total Mean
a	You	Break-even financially	3.78	1.92	1.9	2.68
b	You	Maintain service volume	2.22	2.54	-0.3	2.41
c	You	Maintain service quality	1.67	2.15	-0.5	1.95
d	You	Expand revenue	4.56	3.00	1.6	3.64
e	You	Expand service volume	3.67	3.54	0.1	3.59
f	You	Expand service quality	2.33	3.31	-1.0	2.91
g	You	Other (specify)	4.40	4.50	-0.1	4.45
h	Most Service/Business Managers	Break-even financially	1.57	2.69	-1.1	2.30
j	Most Service/Business Managers	Maintain service volume	3.00	2.23	0.8	2.50
k	Most Service/Business Managers	Maintain service quality	2.14	2.54	-0.4	2.40
m	Most Service/Business Managers	Expand revenue	2.57	3.54	-1.0	3.20
n	Most Service/Business Managers	Expand service volume	3.14	3.62	-0.5	3.45
p	Most Service/Business Managers	Expand service quality	3.00	3.54	-0.5	3.35
q	Most Service/Business Managers	Other (specify)	6.67		6.7	5.38
r	Most Consultants	Break-even financially	4.25	4.85	-0.6	4.62
s	Most Consultants	Maintain service volume	2.63	2.85	-0.2	2.76
t	Most Consultants	Maintain service quality	1.88	2.46	-0.6	2.24
u	Most Consultants	Expand revenue	4.00	5.08	-1.1	4.67
v	Most Consultants	Expand service volume	3.38	3.38	0.0	3.38
w	Most Consultants	Expand service quality	2.50	3.00	-0.5	2.81
x	Most Consultants	Other (specify)	4.00	4.43	-0.4	4.30
y	The Trust Now	Break-even financially	1.75	1.77	-0.0	1.76
z	The Trust Now	Maintain service volume	3.63	2.85	0.8	3.14
aa	The Trust Now	Maintain service quality	2.50	2.92	-0.4	2.76
ab	The Trust Now	Expand revenue	2.75	2.69	0.1	2.71
ac	The Trust Now	Expand service volume	2.88	3.38	-0.5	3.19
ad	The Trust Now	Expand service quality	2.63	4.08	-1.5	3.52
ae	The Trust Now	Other (specify)	6.67		6.7	5.56
af	The Trust Ideally	Break-even financially	2.88	2.08	0.8	2.38
ag	The Trust Ideally	Maintain service volume	3.38	2.62	0.8	2.90
ah	The Trust Ideally	Maintain service quality	2.75	2.31	0.4	2.48
aj	The Trust Ideally	Expand revenue	2.75	2.46	0.3	2.57
ak	The Trust Ideally	Expand service volume	2.50	3.31	-0.8	3.00
am	The Trust Ideally	Expand service quality	1.75	2.77	-1.0	2.38
an	The Trust Ideally	Other (specify)	4.00		4.0	4.20

6.3.1 Break-Even

The greatest divergence between doctors and managers lay in their views about the importance of financial break-even. Managers saw it as the most important duty to themselves whereas consultants perceived it as being among the least important factors. Hospital A shows an interesting lack of consistency in what managers think about their own goals (question 2a) compared to what they believe about the sub-group of service/business managers (question 2h). The management group as a whole regards break-even as its own top priority but believes that maintaining volume and quality is more important to their service/business manager colleagues. A detailed analysis of response patterns (Appendix 2c) shows that service/business managers themselves endorse this view since three quarters of them (3 out of 4) rank *maintaining service quality* as the most important goal to themselves.

This response is consistent with the interviews conducted at Hospital A during the design phase where, contrary to the hypotheses underpinning the questions, service managers saw their primary role as maintaining the service quality within a break-even constraint and believed that quality or safety ultimately overrides financial considerations. It reflects a tension in decision making at the service/business manager level which was articulated during interviews:

> *'People imagine that my prime concern is a balanced budget, but my job is to provide a children's and women's service. My main concerns are operational, ensuring good practice. But I try to do it within a balanced budget.'*

Doctors believe, to a marked extent, that most service/business managers pursue *break-even* as an overriding priority. This might explain the feeling of deteriorating relationships brought out in Question 5. It is not necessarily a cynical view and the comments by three consultants who were interviewed provided some context:

> *'Service managers would wish to maintain the service in the context of break-even. This is not unlike any other business, e.g. research-based business or other business with professional employees.'*

> *'Trust managers have a completely different perspective. They need to keep afloat, to keep the business going. Patients can't be treated if there is no contract.'*

6.3.2 Revenue Expansion

Expansion of revenue and service volume is not considered to be an important duty by consultants or service/business managers. The interviews suggest that Hospital A had latterly given up on this objective although in the early days of the market it had been important:

'Expand revenue - no. The focus has changed over the last 5 years. We were keener 5 years ago to generate business. We used to visit new GP Fundholders. Now we are sceptical about the arrangement. GP Fundholders have run out of money.'

A consultant described his pessimism about revenue expansion and market behaviour:

'We don't pursue objectives in the same way as in business. We're not in an open market; we're not free to make profits and losses. This is one of the main problems in Obs & Gynae hospital-wide. At Kodak, for example, it would be possible to expand - there is a large pot which the company can tap into if it works hard. The problem in Trusts and Departments is that money is limited. Here we have a new Maternity Unit built to a Rolls Royce model. Yet we're trying to fit 10 people into it to reduce the cost per person per mile. We would have been better to have built a Ford Transit. Everyone would be more comfortable. The Health Authority doesn't have the money for a Rolls Royce, (even though some people in this area would be willing to pay). I have been considering whether a pot of gold could be obtained through private insurance. I am very frustrated. I have been Chairman of the Clinical Directorate. I understand how we are tied in the contracting process. Every hospital charges £1600 per delivery so we can't go above that. If I hadn't been Chairman I wouldn't appreciate or understand the problems. The market has depressed us.'

A senior manager showed equal fatigue:

'It's dispiriting. In the first 2 or 3 years the climate was dynamic. In the last 2 or 3 years it's become a bureaucracy. It's soulless...'

A surprising result of the survey was the extent to which service volume is seen as a relatively low priority by doctors themselves. A comment by a senior manager adds insight to the relationship between volume and quality in the minds of consultants:

'The distinction between volume and quality is another matter. For example, when it comes to diagnostic equipment they tend to justify the case by volume; they use volume to sell the case to managers, when they are really after improved techniques and technology.'

6.4 Question 3. Which body is achieving its main objective?

Individuals were asked to tick against which body they believed was achieving its main objective at the moment. They were allowed to tick more than one from a choice of *Managers*, *Consultants*, *Trust* and *None*. This is an impressionistic question which was intended to convey the mood or attitudes of different groups.

Table 6.4: Response to Question 3

	Managers	Consultants	Trust	None	Count	Ratio Count: Sample
3a: Which Body is Achieving its Main Objective at the Moment?						
a Total Sample	34%	21%	21%	24%	100%	1.5
b Total Consultants	20%	0%	10%	70%	100%	1.1
c Total Managers	39%	31%	26%	4%	100%	1.8
3b) Which Body will Achieve its Main Objective During the Next Three Years?						
a Total Sample	21%	21%	31%	27%	100%	1.3
b Total Consultants	0%	11%	11%	78%	100%	1.0
c Total Managers	30%	25%	40%	5%	100%	1.5
3c) Which Body will Achieve its Main Objective During the Next Six Years?						
a Total Sample	16%	32%	32%	20%	100%	1.4
b Total Consultants	0%	33%	22%	45%	100%	1.0
c Total Managers	23%	32%	36%	9%	100%	1.7

70% of consultants believed that *no-one* was currently achieving their objective. Only one manager, by contrast, (4% of count) believed that *no-one* was achieving their goal while the highest vote (39%) went to *managers* themselves. None of the consultants believed that *consultants* were achieving their aim. In summary, *managers* were seen to be achieving their goals overall.

Asking the same question over a three year period produced a shift away from *managers* towards the overall view that *the Trust* would dominate. The majority of consultants maintained their view that *nobody* would achieve their aims.

Over a six year period consultants continued to believe that *nobody* would dominate (45%) although they perceived a strong shift in their own favour. Managers believed that *the Trust* would be the strongest body with the balance between managers and consultants reversing in the consultants' favour.

The overall impression is that managers feel that they have a degree of control at the moment but that in the longer term they will lose it. Consultants are pessimistic in their view that nobody will get what they want, even over six years, but they rate their chances above those of the managers in the long term.

6.5 Question 4. How have priorities changed since Trust status?

Respondents were asked to rate how their own priorities had changed since Trust status and were asked to take a view on how the Trust priorities had changed during the same period. This question considers dynamic changes in objectives rather than providing a snapshot of current rankings as in Question 2.

Table 6.5: Response to Question 4

Mean Scores: Extent of Change where 1 = Weaker, 2 = No Change and 3 = Stronger

	Your Priorities				Trust's Priorities			
	Doctors	Manager	Sample	*Diff.*	Doctors	Managers	Sample	*Diff.*
Break-even financially	2.22	2.62	2.45	*-0.4*	2.78	2.85	2.82	*-0.07*
Maintain service volume/quality	2.44	2.31	2.36	*0.13*	2.13	2.15	2.14	*-0.02*
Expand service volume/quality	2.33	2.54	2.45	*-0.21*	2.33	2.62	2.50	*-0.29*
Be responsive to patients	2.56	2.85	2.73	*-0.29*	2.22	2.85	2.59	*-0.63*
Be responsive to GPs	2.50	2.69	2.62	*-0.19*	2.44	3.00	2.77	*-0.56*

The responses indicate that all groups feel that these objectives are being pursued with more vigour, both by themselves and by the Trust. The greatest degree of change is reflected in the Trust's energetic pursuit of financial break-even. Both doctors and managers believed that their own responsiveness to patients had increased. Managers thought that this was also true of the Trust, although consultants perceived a lower degree of change by the Trust in this area. The manager-sample was unanimous in its view that the hospital had become more responsive to GPs since Trust status.

The interviews indicate that the Trust had, to some extent, moved to a position where it was at the mercy of GPs:

> *'That was the attraction of Trusts - that efficient hospitals would be allowed to develop through the market. But it hasn't been the case. Problems have arisen because of GPs and through lack of loyalty by GPs. GPs have become power hungry and have lost sight of providing care in an effective way. GPs are moving patients on the basis of leverage.'*

6.6 Question 5a. Since the change to Trust status, how has the relationship changed between consultants and managers?

Consultants and managers were asked to rate whether they thought the relationship between the two groups had deteriorated or improved over the period.

Table 6.6: Response to Question 5a

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	1	*13%*	0	*0%*	1	*5%*	*13%*
2 Worse	5	*63%*	0	*0%*	5	*24%*	*63%*
3 No Change	1	*13%*	1	*8%*	2	*10%*	*5%*
4 Better	1	*13%*	8	*62%*	9	*43%*	*-49%*
5 Much Better	0	*0%*	4	*31%*	4	*19%*	*-31%*
Count	8	*100%*	13	*100%*	21	*100%*	
Mean Rating	2.25		4.23		3.48		

76% of consultants thought that relationships between the two groups had deteriorated, whereas none of the managers believed that relationships had become worse and 92% believed that they had improved. This shows a remarkable difference in perceptions between the groups. Their different experiences of Trust status perhaps square with Question 3 in which none of the consultants believed they were achieving their objectives while managers believed that they themselves were achieving their objectives to a greater extent than anybody else. The pattern of consultant responses suggests that they are distinctly dissatisfied.

Consultants explain the deterioration in terms of '*superficial consultation only*', '*no real consultation - mainly a master servant relationship*', although financial pressures and other strictures were mentioned: '*hands tied by financial restrictions and pressure to increase turnover + restriction to decrease turnover or inpatients if not contractually acceptable.*'

6.7 Question 6a. Since the change to Trust Status, how has the service to patients changed?

Consultants and managers were asked to rate whether they thought the service to patients had deteriorated or improved over the period.

Table 6.7: Response to Question 6a

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	2	*25%*	0	*0%*	2	*10%*	*25%*
2 Worse	1	*13%*	0	*0%*	1	*5%*	*13%*
3 No Change	3	*38%*	2	*17%*	5	*25%*	*21%*
4 Better	2	*25%*	8	*67%*	10	*50%*	*-42%*
5 Much Better	0	*0%*	2	*17%*	2	*10%*	*-17%*
Count	8	*100%*	12	*100%*	20	*100%*	
Mean Rating	2.63		4.00		3.45		

38% of consultants believed that services had deteriorated, 38% saw no change and only 25% saw an improvement, whereas 84% of managers believed that services had improved.

In passing, it might be noted that an external perception was provided by the local MP at the time who, on the basis of his mail bag, believed that services had improved: *'It's a very good hospital. It's got a lot of strengths, no doubt about it. It's very much more highly regarded now than it was when I was first MP. We used to get a lot of complaints back in the mid 80s but I get very, very few complaints now. If you look at the Patient's Charter League Tables for Hospital A it is scoring terribly well, and the various units they have set up there, they are all going very well. I do believe it's an excellent hospital. And that's the impression I get from 99.5% of my constituents.'*

6.8 Question 7. Since the change to Trust status, do you think the goals of consultants and managers have .....?

Moved closer together *Not changed* *Moved further apart*

Managers believed that objectives had converged. The majority of consultants, however, believed that goals had moved further apart. Only 11% of consultants believed that goals of the two groups had moved closer together.

Table 6.8: Response to Question 7

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Moved closer together	1	*11%*	9	*69%*	10	*45%*	*-58%*
2 Not changed	1	*11%*	3	*23%*	4	*18%*	*-12%*
3 Moved further apart	7	*78%*	1	*8%*	8	*36%*	*70%*
Count	9	*100%*	13	*100%*	22	*100%*	
Mean Rating	2.67		1.38		1.91		

6.9 Question 8. Which group, in your view, has the most control over the following aspects of service?

Table 6.9: Response to Question 8

Question 8. Which group, in your view, has the most control over the following aspects of service?

	Consultants	Nurses	Managers	Chief Executive	Trust Board	Purchasers	Other	Count
(a) Development of service								
Doctors	1	0	0	6	0	0	2	9
Managers	3	0	0	8	0	1	1	13
Total	4	0	0	14	0	1	3	22
(b) Availability of services (e.g. beds, theatres)								
Doctors	0	0	2	7	0	0	0	9
Managers	2	0	5	4	2	0	0	13
Total	2	0	7	11	2	0	0	22
(c) Medical staffing levels								
Doctors	2	0	1	5	0	0	1	9
Managers	5	0	3	1	3	0	1	13
Total	7	0	4	6	3	0	2	22
(d) Nurse staffing levels								
Doctors	0	0	2	2	1	0	2	7
Managers	0	1	9	2	1	0	2	15
Total	0	1	11	4	2	0	4	22
(e) Freedom to admit in-patient								
Doctors	1	0	5	1	0	0	0	7
Managers	11	0	2	1	0	0	0	14
Total	12	0	7	2	0	0	0	21
(f) Decision to treat patient								
Doctors	7	0	1	0	0	1	0	9
Managers	13	0	0	0	0	0	0	13
Total	20	0	1	0	0	1	0	22
Count for all categories								
Doctors	11	0	11	21	1	1	5	50
Managers	34	1	19	16	6	1	4	81
Total	45	1	30	37	7	2	9	131
% Across All Categories								
Doctors	22%	0%	22%	42%	2%	2%	10%	100%
Managers	42%	1%	24%	20%	7%	1%	5%	100%
Total	34%	1%	23%	28%	5%	2%	7%	100%

The purpose of this question was to examine people's perception of power in terms of control of activities and resources. The only area in which managers are perceived to have control is in the area of nurse staffing levels. As the nursing workforce comprises nearly 50% of the total workforce this indicates that managers have a strong element of control in balancing expenditure with the budget to achieve financial break-even. Quality, equated with safety, will form part of the manager's decision-making process and, since this will be the product of professional judgement by other nurses, the budgetary control is likely to be influenced by the opinion of professionals. A service manager described how she breached the budget to ensure a safe service:

> *'Maintaining the quality of service often overrides the financial goal when the chips are down, e.g. I had to put in some extra nurses into A&E and maternity even though there is no budget to fund them, just to ensure quality and safety of the service. But break-even is also in mind.'*

Consultants in Hospital A perceive the Chief Executive to be the most dominant agent, with purchasers being seen as having very little control. The only category in which consultants believe they have control lies in the decision to treat patients. Doctors believe that managers control admission of patients whereas managers believe that doctors have this power. Managers also believe that doctors have the most control over medical staffing levels whereas the consultants themselves believe that this power resides with the Chief Executive. The CEO is also regarded by both groups as having control in development of services. Responses to this question suggest that the CEO is perceived as something of an autocrat by consultants. The advantages and disadvantages of this style were articulated by a manager in an interview:

> *'I think of the Trust as K [the CEO]. He has an autocratic style. This can thwart initiative and shouldering of responsibility. To sum it up, on the negative side people don't get developed or empowered so they either leave or get comfortable; on the positive side it is possible to build up a good relationship of trust and loyalty with the CEO which is reciprocated'.*

One consultant expressed a rather less charitable opinion in the questionnaire: '*Consultants have been sidelined by the chief executive who has successfully structured the establishment so that all financial decisions are taken by his acolytes.*' The Chief Executive would take a different view of involvement of clinicians since during an interview he noted that *'All Clinical Directorate Chairs were given the opportunity to take responsibility for resource issues but elected to let their managers take accountability.'* He also pointed out that '*Consultants have a different mind set. They have a view of themselves as priests of the NHS. Attempts at managing them tend to be fought off successfully. Managers see themselves as in charge. Doctors also see themselves as in charge. They don't like having to manage and don't like the curbs that that imposes, but they have to play the game to get the resources. They can use their collective power to break the situation; they always win... they always win.'*

6.10 Question 10. Would you welcome change in the future?

The data drawn from the questionnaire survey so far indicates that Hospital A's financial problems have created an environment which has dispirited the consultant body. Although they do not care about financial break-even themselves they do not believe that they have control over resources. In their opinion, power is largely vested in the Chief Executive although in his opinion consultants have the power to *'break the situation'*. This indicates a degree of conflict and frustration which the managers themselves are aware of but do not share.

Responses to the free-text Question 10 add further weight to the picture of consultant disenchantment, feeling of disempowerment and financial pressures. '*Doctors have too little influence in clinical matters and are not involved in any managerial discussions that involve clinical care (hence loss of all our beds). Would like more medical input into the running of the unit. Doctors would like more useful management input and a more equal relationship with managers.*' The competition between Hospital A and a neighbouring Trust also features in consultants' responses: '*Two hospitals linked in a battle 'to the death' is desperately destructive of morale. They must link together and not fight each other. Trust status has been very damaging.*'

6.11 Conclusion

The questionnaire responses are summarised here on the basis of the postal questionnaire but also incorporate data from the earlier interview phases (which targeted a smaller sample). These two data sources provide mutually consistent results since the responses of the written questionnaire are in keeping with the tone and content of the earlier interviews in Hospital A (italicised in quotations throughout this chapter). This is reassuring in terms of questionnaire design since it suggests that the structure of closed and open questions captures the qualitative content of doctors' and managers' views as accurately as would a face to face interview where the respondent has an opportunity to ask for guidance and clarification.

The question about objectives (Question 2) produced results which are in line with the overall hypotheses since doctors and managers voted for *quality* and *financial break-even* respectively. The responses suggest a finer balance than originally predicted, however, within the management group between financial duties and quality issues due to diversity of their roles. Service/business managers are closer to the point of service delivery, and therefore to consultants, than are their senior and corporate colleagues. This category is perceived by the management group as a whole as being more concerned about service delivery (quality and volume) than about financial management. Service/business managers themselves endorse this perception by ranking *maintaining service quality* as their first priority above *financial break-even*. This indicates a degree of tension within the management group. Since service/business managers are budget holders, their alignment with consultants could, on the one hand,

strengthen the power of consultants and, on the other, shift the balance of objectives within the management group as a whole. The choice between service and budgetary considerations is taken forward for testing against a larger sample through the national survey.

The mood of the hospital appears to be captured by questions 3, 5, 6 and 7 which ask about who is achieving their objective in the hospital, how relationships and patient services have faired since Trust status, and whether the goals of doctors and managers have converged. The perceptions of consultants and managers differed widely in this survey, with consultants adopting a deeply pessimistic outlook which was consistent throughout these four questions.

Question 8 is designed to test the consistency of views about who has control over decisions and resources in a Trust. Managers attributed power mainly to consultants although the clinicians themselves believed that the CEO had most control, again showing a difference in perception and a feeling of disempowerment on the part of consultants.

This survey sets the scene for the national study which moves from the particular case of Hospital A to a larger sample of Trusts, permitting generalisations to be made about the attitudes and motivation of consultants and managers within Trusts.

CHAPTER 7. QUESTIONNAIRE SURVEY: RESULTS OF STAGE 2 (CLOSED QUESTIONS)

This chapter brings together part of the findings of the national survey, i.e. Stage 2, by analysing the results of the closed questions.

The survey was administered over the period September-October 1997, preceding the Labour Government's White Paper published in December 1997 (Department of Health, 1997). The response of 1,577 was equivalent to 34% of the original mail shot and 56% of the sample among participating Trusts.

Table 7.1: Response Rate

RESPONSE RATE				
TRACKING SHEETS	124	indicating participation through Chief Executive's Office		
Questionnaires returned from	143	Trusts		
EQUIVALENT TO	2824	Questionnaires		
	60%	out of	4680	questionnaires sent
Number of Questionnaires returned				
	1577	out of	2824	questionnaires in participating sample
Response Rate =	**56%**	out of participating Trusts, and		
	34%	of the total mail shot		

The sample of 1,577 respondents produced more than 1,800 descriptions due, for example, to consultants describing themselves as both Board Director and Consultant, or Clinical Professionals being also Service/Business Managers. Double counting was eliminated by adopting a priority classification which resulted in the following profile of respondents:

Table 7.2: Respondent Categories

	Total	*of whom*		*Category*
Consultants	**681**	*330*	*1.*	*Chair Clinical Directorates*
		36	*2.*	*Board Director*
		315	*3.*	*Consultants Only*
Managers	**896**	*5*	*4.*	*Chair*
		73	*5.*	*CEO*
		221	*6.*	*Board Director*
		131	*7.*	*Corporate*
		81	*8.*	*Clinical Professional*
		316	*9.*	*Service/Business Manager*
('Other' mainly comprises service/		61	*10.*	*Other Manager*
		8	*11.*	*Unidentified*
Total	**1,577**	*1,577*		

7.1 Question 1. To what extent does your career depend on the following factors?

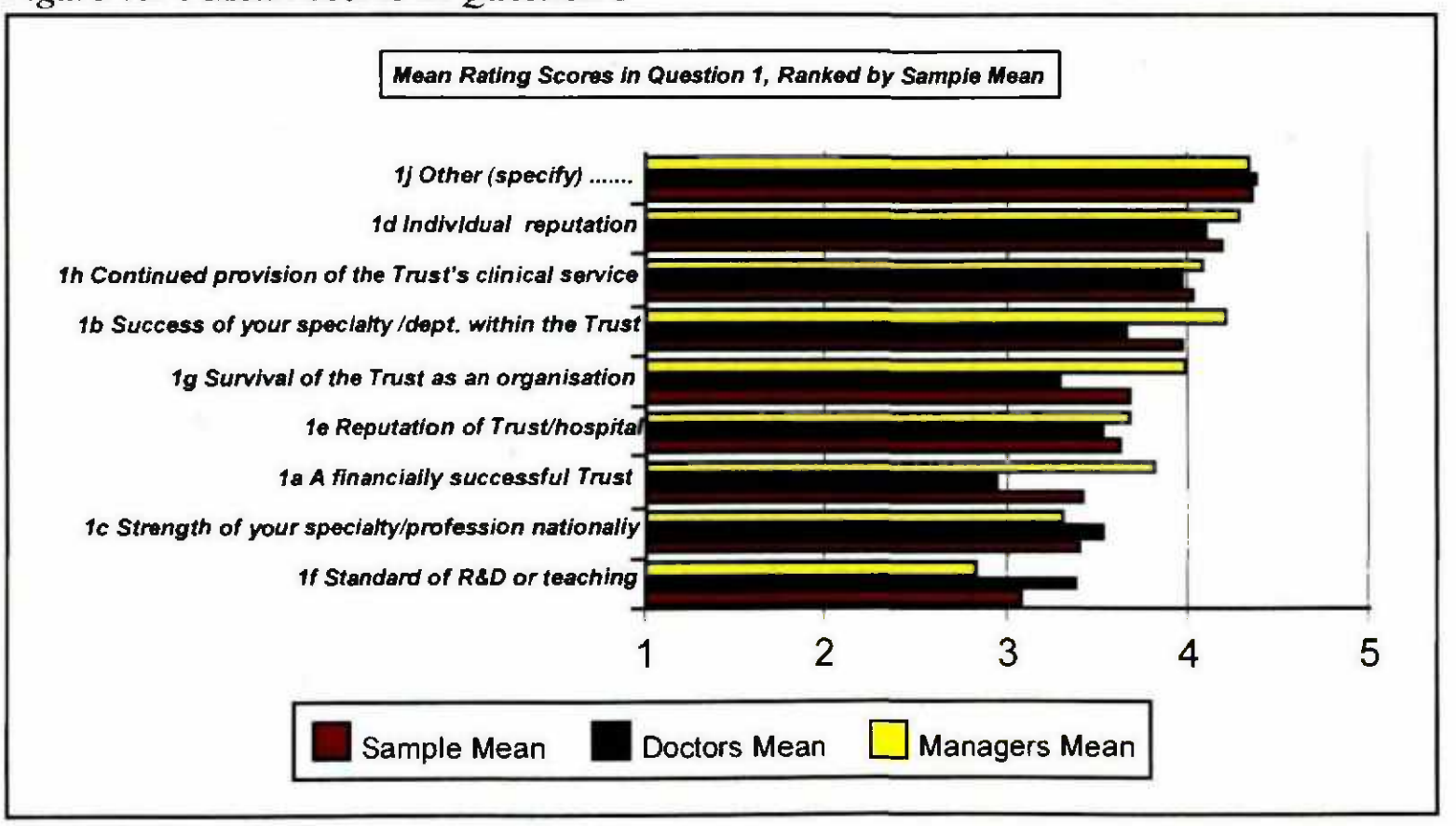
Respondents were asked in the first place to rate the importance to their own career of 8 selected factors, and were also given the opportunity to specify a ninth factor. (Approximately 10% of respondents used this opportunity).

The table below shows the mean value of ratings 1 - 5 where *1=very low, 2=low, 3=moderate, 4=high,* and *5=very high* in importance. The largest contrast between doctors and managers is to be found in *1(a) - Financially Successful Trust.* Doctors on average regarded this as *moderate*, verging towards *low* in importance while managers regarded it as having *high* importance to their own careers. The smallest difference lies in *1(h) - Continued provision of the Trust's clinical service.* ANOVA tests are applied below to check whether any of these differences can be regarded as significant.

Table 7.3: Comparison of Raw Mean Rating Scores in Question 1

	1a	1b	1c	1d	1e	1f	1g	1h	1j
Sample Mean	3.424	3.968	3.413	4.194	3.621	3.076	3.683	4.023	4.348
Sample Standard Deviation	*1.032*	*0.862*	*0.962*	*0.756*	*0.805*	*1.032*	*1.071*	*0.913*	*0.874*
Doctors Mean	2.929	3.662	3.527	4.096	3.540	3.385	3.295	3.960	4.362
Doctors Standard Deviation	*1.046*	*0.939*	*0.892*	*0.829*	*0.825*	*0.957*	*1.126*	*0.908*	*0.874*
Managers Mean	3.802	4.209	3.324	4.269	3.684	2.837	3.980	4.071	4.339
Managers Standard Deviation	*0.845*	*0.710*	*1.006*	*0.686*	*0.785*	*1.025*	*0.924*	*0.914*	*0.877*
Difference									
Doctor - Manager Means	-0.873	-0.547	0.203	-0.173	-0.144	0.548	-0.685	-0.111	0.023

Figure 7.1 : Mean Scores in Question 1



The graph above highlights the result that both doctors and managers regard *1(d), personal reputation,* as the most important factor to their career among the closed set of options. In addition:

- managers gave substantially higher ratings to the importance of *'Survival of the Trust as an organisation';*
- managers also regarded the *'success of your specialty/dept. within the Trust'* as considerably more important than did consultants;
- out of the nine factors above, managers gave a higher average score in seven. The two which consultants considered to be more important were *1c 'Strength of your specialty/department within the Trust'* and *1f 'Standard of R&D/Teaching'.*

The results of the ANOVA test shown below indicate that there is a significant difference in the responses of doctors and managers for all factors in Question 1, with the exception of *1(j) - Other.*

Table 7.4: ANOVA Results in Two Respondent Groupings: Doctors and Managers

	Probability	Difference Significant at 0.05? ANOVA	Difference Significant at 0.01? ANOVA
1a	0	✓	✓
1b	0	✓	✓
1c	0	✓	✓
1d	0	✓	✓
1e	0.001	✓	✓
1f	0	✓	✓
1g	0	✓	✓
1h	0.0073	✓	✓
1j	0.9517	x	x

The test was repeated within doctors (categories 1-3) and managers (categories 4-9) and then across all categories (1-9)[22].

Table 7.5: ANOVA Test Within Doctor and Manager Groupings

		Doctors 1-3 Probability	Managers 4-9 Probability	All 1-9 Probability
1a	A financially successful Trust	0.7869	0 **	0 **
1b	Success of your specialty /dept. within the Trust	0.5029	0.0083 **	0 **
1c	Strength of your specialty/profession nationally	0.81	0.0002 **	0 **
1d	Individual reputation	0.425	0.0874	0.0002 **
1e	Reputation of Trust/hospital	0.0782	0 **	0 **
1f	Standard of R&D or teaching	0.8984	0.0309 *	0 **
1g	Survival of the Trust as an organisation	0.1097	0.0164 *	0 **
1h	Continued provision of the Trust's clinical service	0.2945	0.0239 *	0.0033 **
1j	Other (specify)	0.7566	0.8882	0.9694

* = Significant at 0.05 level but not at 0.01 ** = Significant at 0.01 level

[22] Categories 10 (other managers) and 11 (unknown) were omitted due to size, even though the questionnaire descriptions indicated that most mangers in category 10 would probably belong to category 9 (service/business managers)

The results show that there is no significant difference in responses between doctors but that there exists a greater degree of heterogeneity between managers. The differences between all categories are stronger than the differences between managers, indicating that the doctor/manager split is the stronger line of division. This is consistent with the underlying hypothesis of this exercise which is that managers and doctors are driven by different motivators.

The difference within the manager group has been explored by considering (a) the distinction between Corporate category 7 and Clinical category 8 which show a potentially significant division (see Question 1a detailed below), and (b) Chair+CEO+Director+Corporate Categories 4-7 compared to Clinical+Service/Business+Other+Unidentified. The results are set out below and show that the division between the two corporate and clinical professional groups is stronger than the aggregated divisions in (b).

Table 7.6: ANOVA Test - Dividing Up the Manager Group

		(a) 7& 8 *Probability*	(b) 4-7 & 8-11 *Probability*
1a	A financially successful Trust	0.0015**	0**
1b	Success of your specialty /dept. within the Trust	0.0845	0.0456*
1c	Strength of your specialty/profession nationally	0.0031**	0.1708
1d	Individual reputation	0.0093**	0.141
1e	Reputation of Trust/hospital	0.0779	0.0001 **
1f	Standard of R&D or teaching	0.0981	0.9752
1g	Survival of the Trust as an organisation	0.0094**	0.0116*
1h	Continued provision of the Trust's clinical service	0.03*	0.9188
1j	Other (specify)	0.5673	0.7787

* = Significant at 0.05 level but not at 0.01 ** = Significant at 0.01 level

The Chi Squared results summarised below mirror the ANOVA test, with the exception of *1(h) Continuation of Trust's clinical service* which narrowly fails the 5% test, indicating that the difference between doctors' and managers' responses is not significant, (consistent with the finding earlier that the mean ratings vary by only -0.111 between the groups). The differences between groups of respondents has been tested in two ways: (i) by retaining the eleven different groupings (where 'unknown' is the eleventh group), and (ii) by grouping doctors and managers into two categories. The results of the doctor/manager grouping (first method) are very similar to those of the second grouping method, suggesting that significant differences are largely attributable to differences between doctors and managers rather than within groups.

Table 7.7: First Method of Grouping: Eleven Categories of Individuals

	Chi Squared		Difference	Difference
	Pearson	Likelihood	Significant at 0.05?	Significant at 0.01?
	p =	Ratio	(Pearson Chi Squared)	(Pearson Chi Squared)
1a	0	0	✓	✓
1b	0	0	✓	✓
1c	0	0.00001	✓	✓
1d	0.00004	0.00001	✓	✓
1e	0	0.00003	✓	✓
1f	0	0	✓	✓
1g	0	0	✓	✓
1h	0.05492	0.03945	✗	✗
1j	0.90651	0.83848	✗	✗

Table 7.8: Second Method of Grouping: Doctors & Managers as Two Categories

	Chi Squared		Difference	Difference
	Pearson	Likelihood	Significant at 0.05?	Significant at 0.01?
		Ratio	(Pearson Chi Squared)	(Pearson Chi Squared)
1a	0	0	✓	✓
1b	0	0	✓	✓
1c	0.00002	0.00001	✓	✓
1d	0.00002	0.00002	✓	✓
1e	0.00108	0.00093	✓	✓
1f	0	0	✓	✓
1g	0	0	✓	✓
1h	0.05167	0.0515	✗	✗
1j	0.76984	0.64732	✗	✗

The strongest result in terms of doctor/manager differences is in the importance of the Trust's financial success. The table below summarises the mean rating score provided by each of the groups together with their standard deviation and a ranking order of the mean rating scores. (A score below 3 veers towards the *unimportant* end of the scale). At a glance there is consistency between the average importance attributed to financial success and the position of the individual within the hierarchy. Chief Executives attach most importance followed by non-medical Board Directors moving steadily through the corporate and service manager tiers to managers with a clinical professional background. The three groups of consultants are below the line (less than 3) and stand out as a contrast to the managers in their responses.

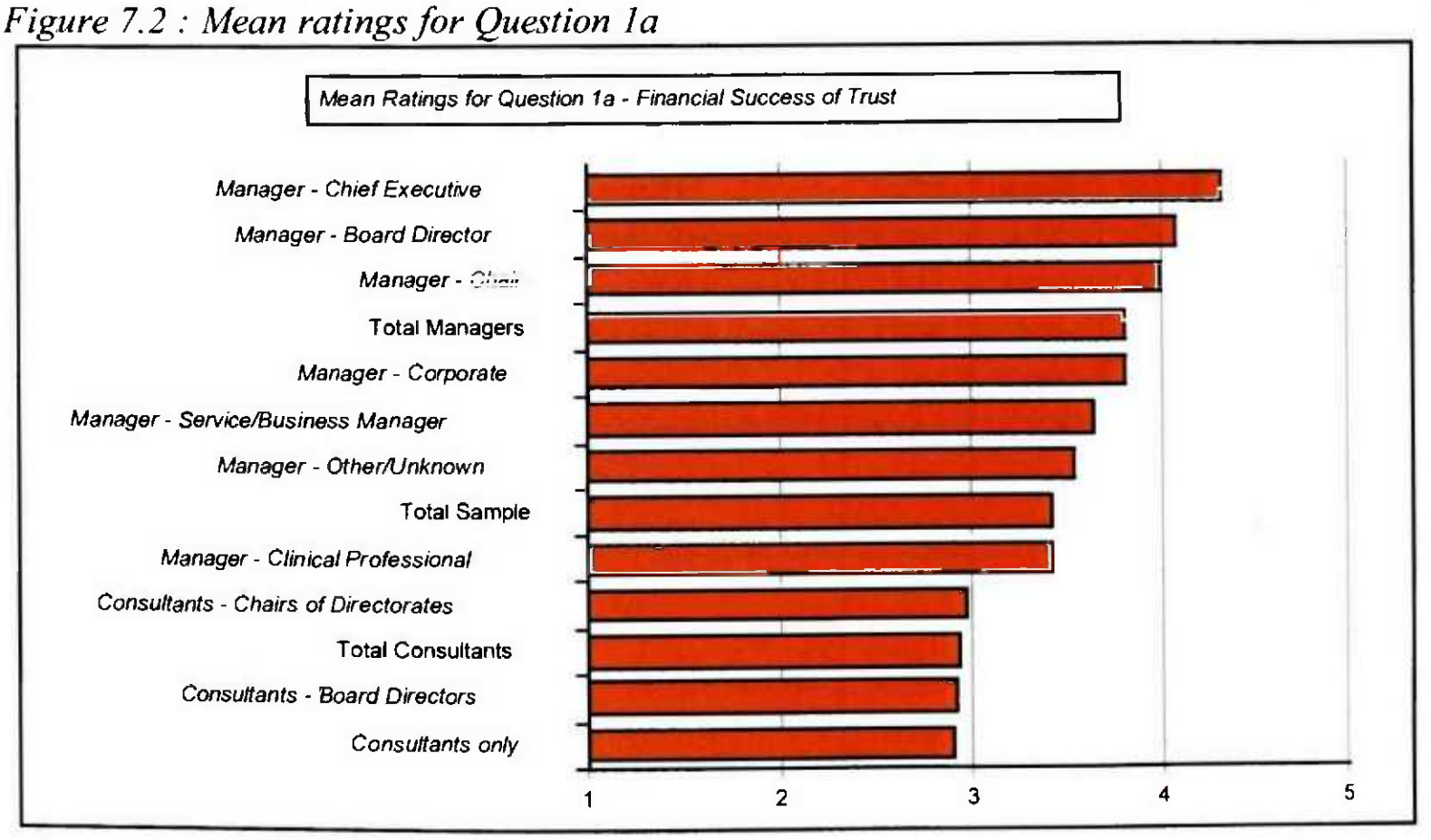
Table 7.9 : Mean ratings for Question 1a

Q1. To what extent does your own career depend on:

1a A financially successful Trust

		Mean	*Ranked Means*	*Standard Deviation*
a	**Total Sample**	**3.424**		**1.032**
b	**Total Consultants**	**2.929**		**1.046**
c	**Total Managers**	**3.802**		**0.845**
1	Consultants - Chairs of Directorates	2.958	8	1.074
2	Consultants - Board Directors	2.917	9	0.841
3	Consultants only	2.901	10	1.039
4	Manager - Chair	4.000	3	1.225
5	Manager - Chief Executive	4.329	1	0.625
6	Manager - Board Director	4.068	2	0.796
7	Manager - Corporate	3.800	4	0.875
8	Manager - Clinical Professional	3.413	7	0.807
9	Manager - Service/Business Manager	3.645	5	0.816
10	Manager - Other/Unknown	3.544	6	0.800

Figure 7.2 : Mean ratings for Question 1a



7.2 Responses to Question 2. Within the Trust, how would you rank the priorities for the following sets of people?

This question focuses on the central question of objectives of managers and doctors. It is intended to permit analysis of individuals' views about their own objectives and to consider how they are seen by other people. Respondents were asked to rank objectives in order of priority 1-7 where 1 is high. The results of Kruskal-Wallis and Mann-Whitney U tests (non-

parametric alternatives to ANOVA, summarised in Appendix 4) proved to be almost identical to the ANOVA test, suggesting that the comparison of means on this ordinal data does not produce distorted results. The table below summarises the mean ranking and significance at the 5% and 1% where the null hypothesis of similar populations fails (i.e. where the responses of consultants and managers are significantly different).

Table 7.10: Two Groups: Doctors and Managers - Mean Ranking Scores

	Priorities Perceived as Belonging to :	***Objective***	**Doctors' Mean**	**Managers' Mean**	**Diff.**	**ANOVA significance 5%* only and 1%****
2 a	You	*Break-even financially*	3.908	2.037	1.9	0 **
2 b	You	*Maintain service volume*	2.754	2.593	0.2	0.0477 *
2 c	You	*Maintain service quality*	1.776	2.281	-0.5	0 **
2 d	You	*Expand revenue*	4.076	3.457	0.6	0 **
2 e	You	*Expand service volume*	3.472	3.433	0.0	0.6714
2 f	You	*Expand service quality*	2.124	2.792	-0.7	0 **
2 g	You	*Other (specify)*	2.97	3.459	-0.5	0.0004**
2 h	Most Service/Business Managers	*Break-even financially*	1.557	2.08	-0.5	0 **
2 j	Most Service/Business Managers	*Maintain service volume*	2.505	2.374	0.1	0.063
2 k	Most Service/Business Managers	*Maintain service quality*	3.067	2.484	0.6	0 **
2 m	Most Service/Business Managers	*Expand revenue*	2.798	3.185	-0.4	0 **
2 n	Most Service/Business Managers	*Expand service volume*	3.419	3.262	0.2	0.0536
2 p	Most Service/Business Managers	*Expand service quality*	3.968	3.241	0.7	0 **
2 q	Most Service/Business Managers	*Other (specify)*	5.223	4.545	0.7	0 **
2 r	Most Consultants	*Break-even financially*	4.601	4.54	0.1	0.4216
2 s	Most Consultants	*Maintain service volume*	2.565	2.762	-0.2	0.0110*
2 t	Most Consultants	*Maintain service quality*	1.756	2.3	-0.5	0 **
2 u	Most Consultants	*Expand revenue*	4.245	4.085	0.2	0.0746
2 v	Most Consultants	*Expand service volume*	3.154	2.821	0.3	0.0001 **
2 w	Most Consultants	*Expand service quality*	2.126	2.297	-0.2	0.0150 *
2 x	Most Consultants	*Other (specify)*	3.263	2.847	0.4	0.0004 **
2 y	The Trust Now	*Break-even financially*	1.479	1.492	-0.0	0.7873
2 z	The Trust Now	*Maintain service volume*	2.648	2.53	0.1	0.1176
2 aa	The Trust Now	*Maintain service quality*	3.107	2.707	0.4	0 **
2 ab	The Trust Now	*Expand revenue*	2.766	2.966	-0.2	0.0116 *
2 ac	The Trust Now	*Expand service volume*	3.459	3.369	0.1	0.2815
2 ad	The Trust Now	*Expand service quality*	3.939	3.452	0.5	0 **
2 ae	The Trust Now	*Other (specify)*	4.814	4.04	0.8	0 **
2 af	The Trust Ideally	*Break-even financially*	2.911	2.177	0.7	0 **
2 ag	The Trust Ideally	*Maintain service volume*	3.175	3.023	0.2	0.1143
2 ah	The Trust Ideally	*Maintain service quality*	2.609	2.738	-0.1	0.16
2 aj	The Trust Ideally	*Expand revenue*	3.316	3.152	0.2	0.1026
2 ak	The Trust Ideally	*Expand service volume*	3.024	2.945	0.1	0.391
2 am	The Trust Ideally	*Expand service quality*	2.265	2.385	-0.1	0.1298
2 an	The Trust Ideally	*Other (specify)*	3.382	3.196	0.2	0.1566

7.2.1 Your Priorities

Within Question 2 the issue of individuals' own priorities may be regarded as the most revealing in relation to the hypotheses about motivation. Response categories 2a - 2g provide an insight into what individuals believe is most important to themselves.

Two Categories: Doctors and Managers

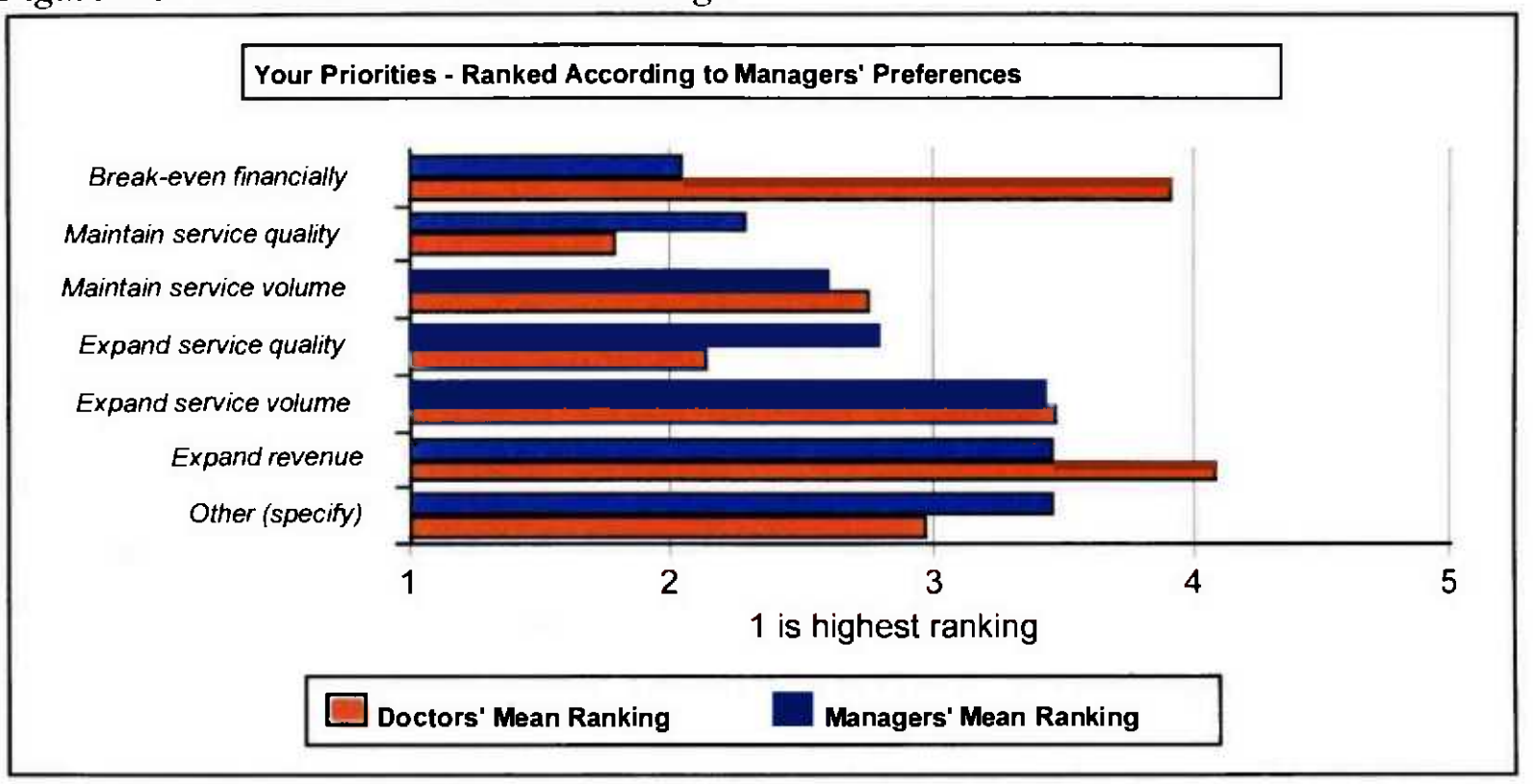
49% of managers (429/875 - see 2a in Appendix 2) ranked *financial break-even* as their number one priority compared to 7% (45/653) of doctors (where the median and modal ranking was 4 out of 7 and the mean score was only marginally higher than that for *expanding revenue)*. A further 19% of managers (170/875) ranked it in second place. The widest divergence in the priorities of doctors and managers is reflected in this area of financial control. The ANOVA tests above show that managers and doctors behave as two independent categories in their responses.

The most important objective among consultants is to *maintain service quality (2c)* where 62% (404/651) ranked this in first place and a further 18% (120/651) ranked it second. Managers also regarded this as an important factor with 67% (586/873) ranking it in first or second place. *Expanding service volume* is a low priority for both groups and, as shown earlier, shows no significant difference in the responses of either consultants or managers.

The difference between the groups' rankings is significant in each area except *service volume. Maintain service volume* produced a difference in responses which had borderline significance at the 5% level; the ANOVA measurement produced a probability $\rho = 0.048$ while the 2-tailed Mann-Whitney test measured $\rho = 0.055$. *Expansion of service* showed a weaker level of difference between the groups' responses, which meant that the null hypothesis of dependence could not be rejected in relation to these objectives.

The graph below summarises the mean ranking set against each objective by both doctors and managers. 1 is the highest ranking so that the smaller the bars, the higher the ranking.

Figure 7.3: Your Priorities - Mean Rankings



Variations within Categories

Mean Responses. Doctors were homogeneous in their responses (Appendix 2a) since all categories i.e. Chairs of clinical directorates, Board Directors and consultants without board or directorate commitments, ranked *maintenance of service quality* in first place with *expansion of service* quality ranked second. Managers, on the other hand, showed marked differences in their response patterns, depending upon where they are located in the hierarchy. The summary of means (shown in Appendix 2b) indicates that Chief Executives, Board Directors and corporate managers clearly rank *financial break-even* above *maintaining service quality.* Clinical managers follow the reverse by ranking *maintaining service quality* above *financial break-even.* The response of service managers, however, is equivocal. By a narrow margin (0.03 mean points) this group accords greater overall importance to *financial break-even* than to *maintaining service quality.* This result is due to the impact of higher volumes of second and third rankings being attached to *financial break-even.*

First Preference. If we consider only the first preference then service/business managers have voted for *maintaining service quality* as their most important goal. The corporate groups of CEO, Board Directors and other corporate managers each placed the need for *financial break-even* above other goals, even though *maintaining quality* in all these cases was ranked as the second priority. Clinical managers gave a clear signal that *maintaining quality* was the most important goal, with three times more people ranking this in first place than *financial break-even (47 cf. 16).* Service managers have produced a somewhat surprising result by asserting that *maintaining quality* is their first priority to a greater extent than *financial break-even.*

Implication. In the context of NHS Trust management this result has important

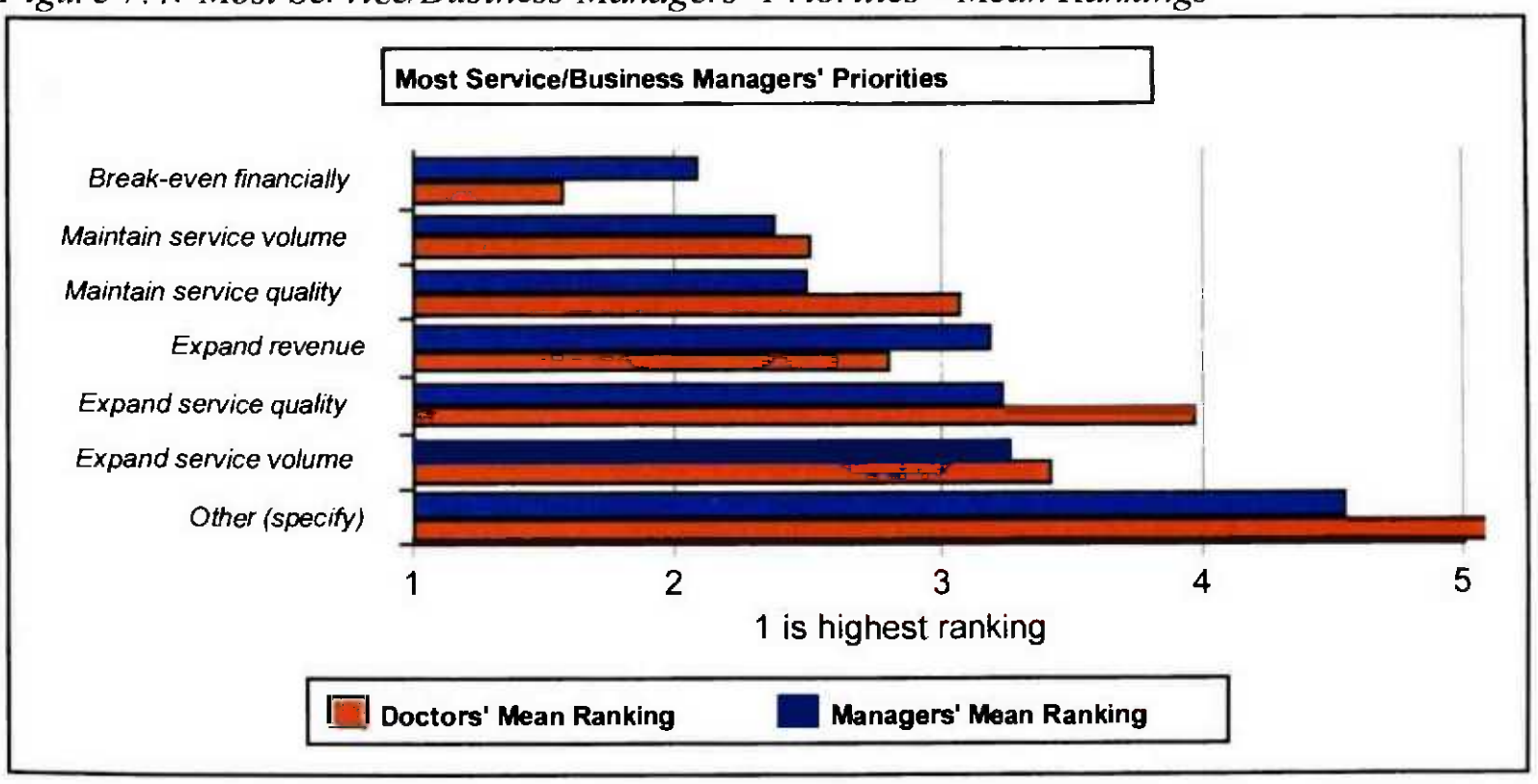
consequences. Service/business managers represent the group which has been accorded responsibility for budgetary management within the Trust Clinical Directorate model of management. Senior managers and directors at the corporate level may set strategic objectives but *financial break-even* must be implemented by the service/business managers who manage budgets on a day to day basis. The responses of this group are similar to those of consultants, in terms of quality, rather than directors and other corporate groups.

It could be argued from these results that quality is likely to override budget constraints within Trusts and that the management structure is designed to implement consultants' wishes rather than those of senior executives.

7.2.2 The Priorities of Most Service/Business Managers

Respondents were asked to state what they thought was important to most service/business managers.

Figure 7.4: Most Service/Business Managers' Priorities - Mean Rankings



Both doctors and managers asserted that they believed *financial break-even* to be the most important goal of service/business managers and so gave this the highest ranking. Although the average ranking attributed by both groups set *financial break-even* above other goals, there were significant differences between the two groups' pattern of responses. 67% of doctors (436/648) took the view that most service/business managers ranked it first compared to 47% (409/864) of managers.

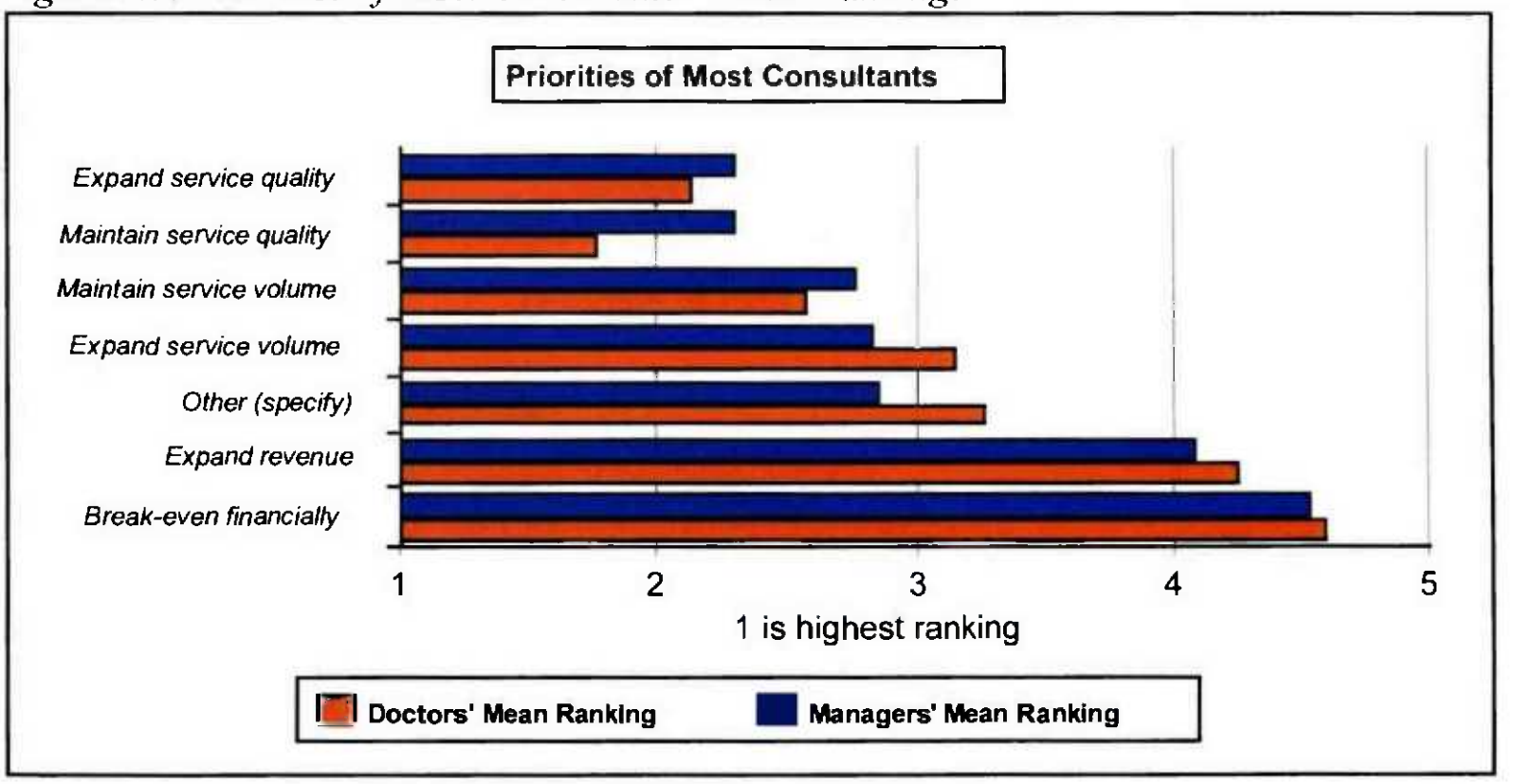
Doctors attributed *financial break-even* to managers in the same measure as they gave weight to *maintaining quality* for themselves, whereas managers ranked *financial break-even* for themselves and for most service/business managers in equal measure. They gave more

importance to *maintaining quality* within their own priorities, however, than they attributed to most service/business managers, taking the view that they had a more conscientious approach to quality than most of their peers.

7.2.3 The Priorities of Most Consultants

Managers and doctors followed similar ranking patterns but with different score magnitudes in all categories with the exception of *service quality* where managers gave equal weight to *expand* and *maintain* whereas consultants clearly elected *maintain service quality* to first place. 62% (391/631) ranked it number one and a further 17% (110/631) ranked it as second priority, reflecting consultants views of themselves as individuals.

Figure 7.5: Priorities of Most Consultants - Mean Rankings



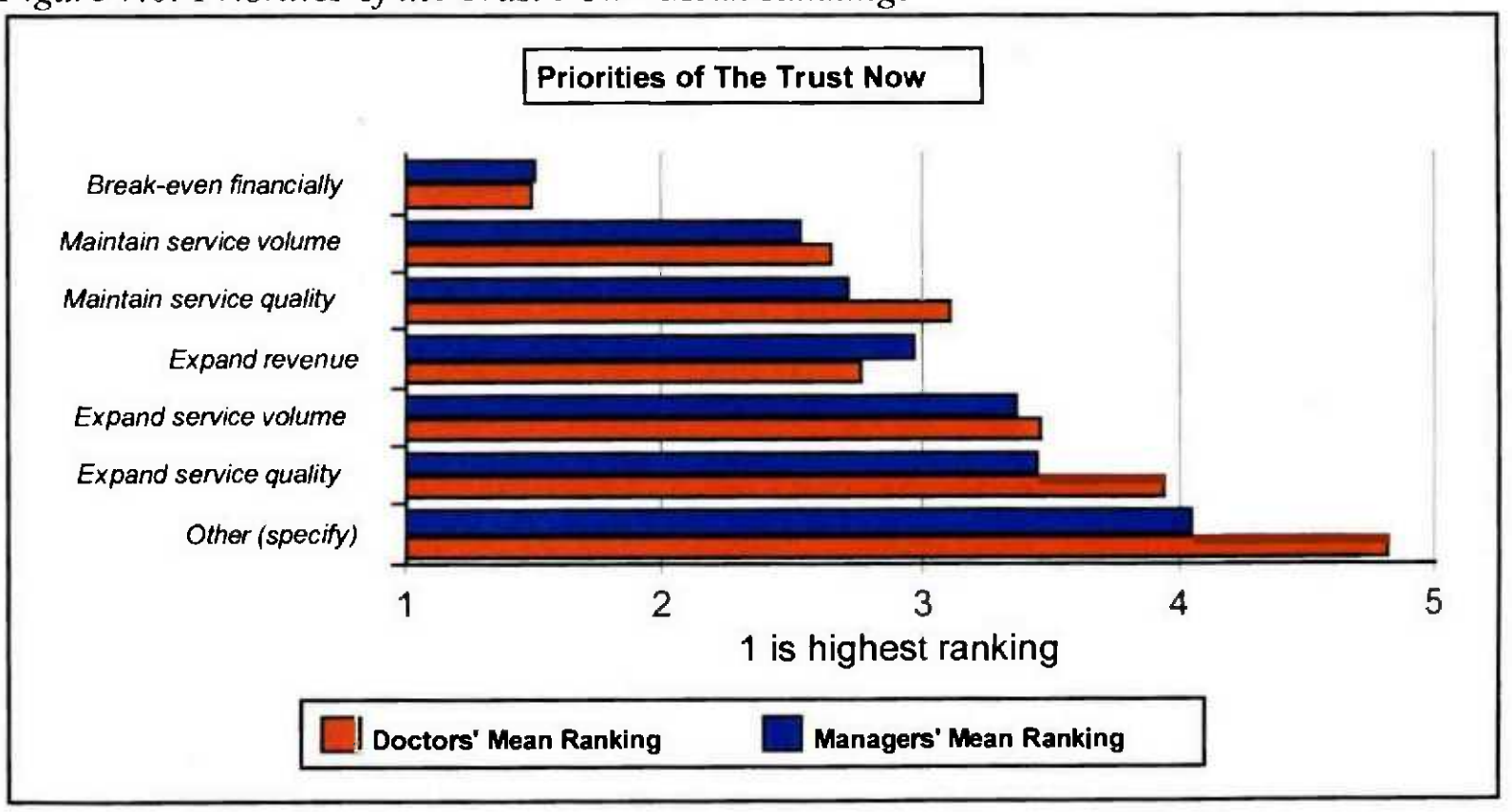
The difference between the rankings of clinicians and managers was significant at the 1% level in relation to *maintain service quality* and at the 5% level for e*xpand quality*. Perceptions of *service volume* also showed significant variation between the groups. Expanding *service volume* was perceived to be less important by consultants themselves than *maintenance of volume*, whereas managers believed that consultants gave this similar weighting. These results showed significant variation at the 5% level *(maintain volume*) and the 1% level (*expand volume*). In financial matters both doctors and managers tended to take the same view. Each group believed that *expanding revenue* was not important to consultants and that *financial break-even* was at the bottom of their priority list. There was therefore no significant difference at either the 5% or the 1% level.

7.2.4 The Priorities of the Trust Now

This questionnaire preceded the White Paper *The New NHS: Modern.Dependable* (December 1997) with its emphasis on clinical governance and so one can only speculate as to the changes in perceptions of Trust priorities post December 1997. At the time of this exercise, however, the perceptions of doctors and managers showed a high degree of consistency with one another. 72% of doctors (459/639) and 72% of managers (620/861) believed that the Trust's main objective is to achieve *financial break-even.*

There is no significant difference between perceptions of both *financial break-even* (ranked first), *maintaining service volume* (ranked second) and *expanding service volume* (ranked fifth). Strong differences emerged in the view of quality since doctors believed that both maintaining and expanding quality was significantly less important to the Trust than did managers. Doctors believed that *expanding revenue* was more important to the Trust than *maintaining quality.*

Figure 7.6: Priorities of the Trust Now - Mean Rankings



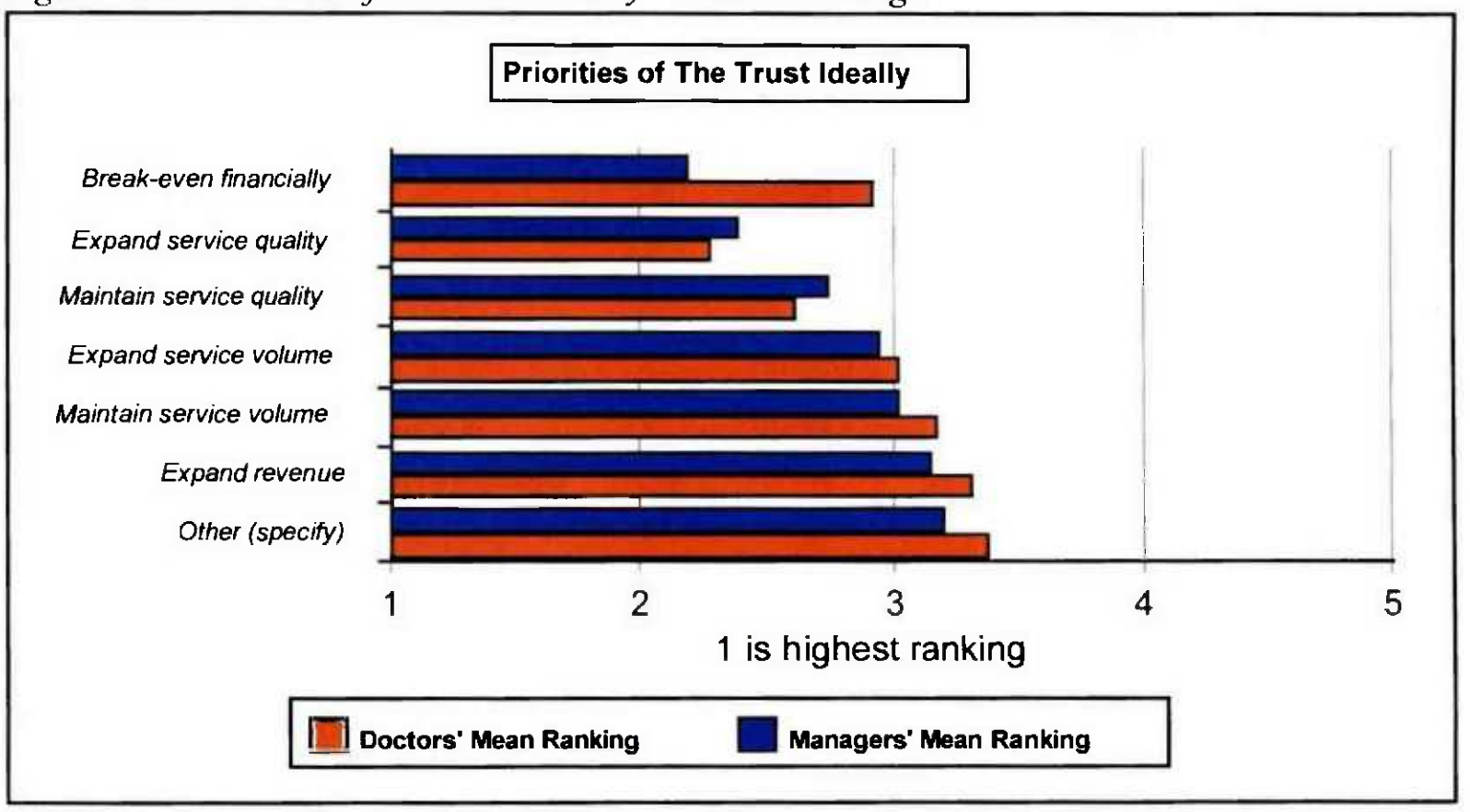
7.2.5 The Priorities of the Trust Ideally

There is no significant difference between what doctors and managers believe the priorities of the Trust should be *ideally*, with the exception of *financial break-even.* Doctors believe that this should be ranked below quality whereas managers ranked it highest overall, consistent with their view of their own priorities. The importance of *service quality* to doctors is consistent with their view of their own objectives.

When we compare perceptions of the *Trust now* and the *Trust ideally* it is apparent that

doctors and managers have clear and similar views about the current set of priorities, showing a sharp discrimination between *financial break-even* and *expand service quality*, for example, whereas the delineation is less marked for the ideal set of priorities, illustrated by the lack of spread in the range of the bars in the graph below.

Figure 7.7: Priorities of the Trust Ideally - Mean Rankings



7.3 Question 3. Which body is achieving its main objective?

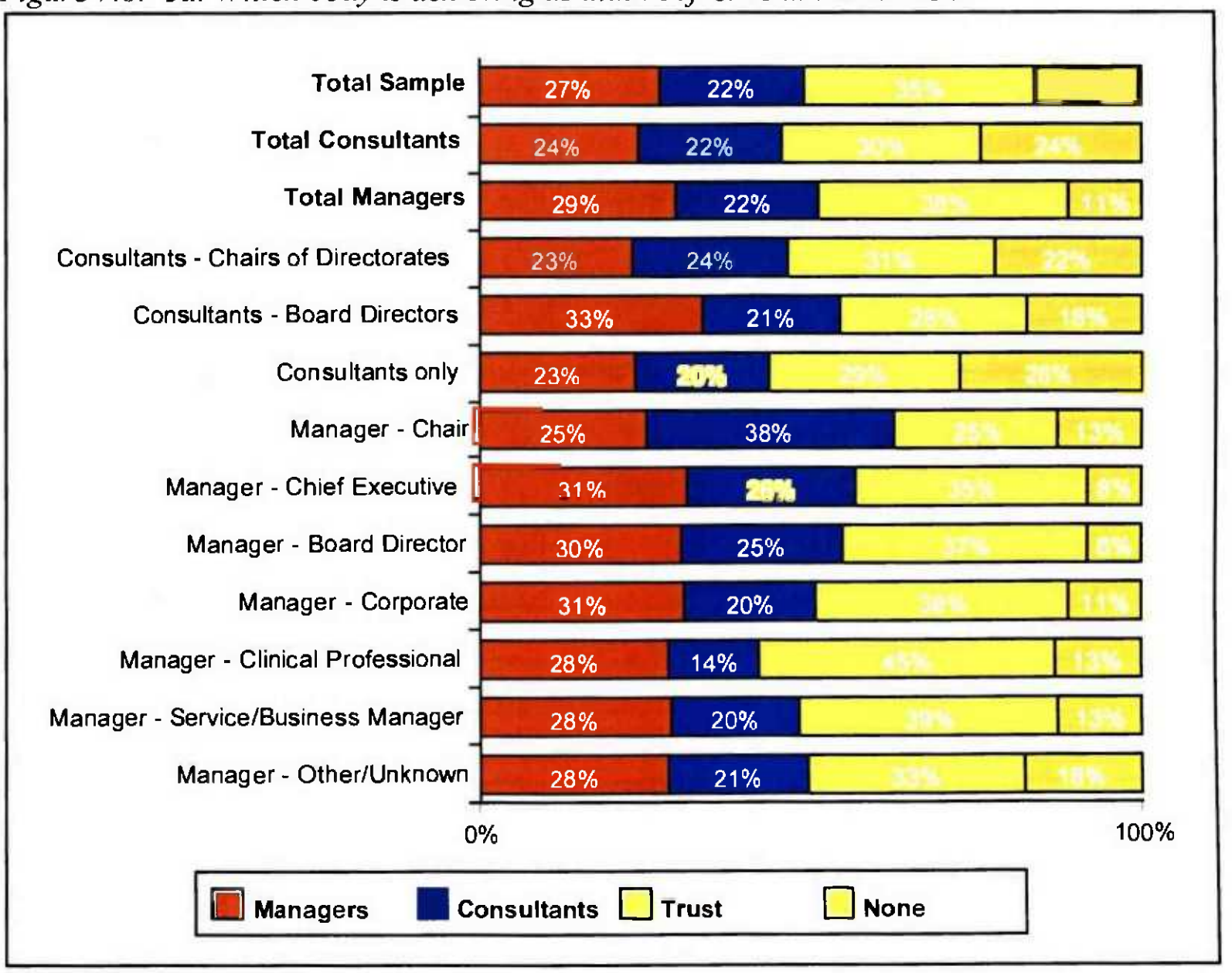
7.3.1 3a) Which body is achieving its main objective now?

The table and graph below show the distribution of opinion. The widest divergence is in *None* where consultants assigned 24% of their vote to suggest that none of the bodies is achieving its objective compared to 11% by managers. This opinion was strongest among the consultants with limited management input (labelled 'consultants only') and was least pronounced in Chief Executives and management Board Directors. Of the three bodies, consultants received the lowest vote at 22%, followed by managers with 27% overall; the largest proportion of ticks went to the Trust with 35% overall, made up of a contrasting 38% vote by managers and 30% vote by consultants.

Table 7.11: 3a: Which body is achieving its main objective at the moment?

		Managers	Consultants	Trust	None	Count	Sample	Ratio Count: Sample
a	**Total Sample**	682	548	876	414	2,520	1,577	1.6
b	**Total Consultants**	236	221	301	244	1,002	681	1.5
c	**Total Managers**	446	327	575	170	1,518	896	1.7
1	Consultants - Chairs of Directorates	115	120	159	113	507	330	1.5
2	Consultants - Board Directors	19	12	16	10	57	36	1.6
3	Consultants only	102	89	126	121	438	315	1.4
4	Manager - Chair	2	3	2	1	8	5	1.6
5	Manager - Chief Executive	45	38	51	12	146	73	2.0
6	Manager - Board Director	127	104	155	35	421	221	1.9
7	Manager - Corporate	70	46	88	25	229	131	1.7
8	Manager - Clinical Professional	34	17	54	16	121	81	1.5
9	Manager - Service/Business Manager	138	96	190	62	486	316	1.5
10	Manager - Other/Unknown	30	23	35	19	107	69	1.6

Figure 7.8: 3a: Which body is achieving its main objective at the moment?



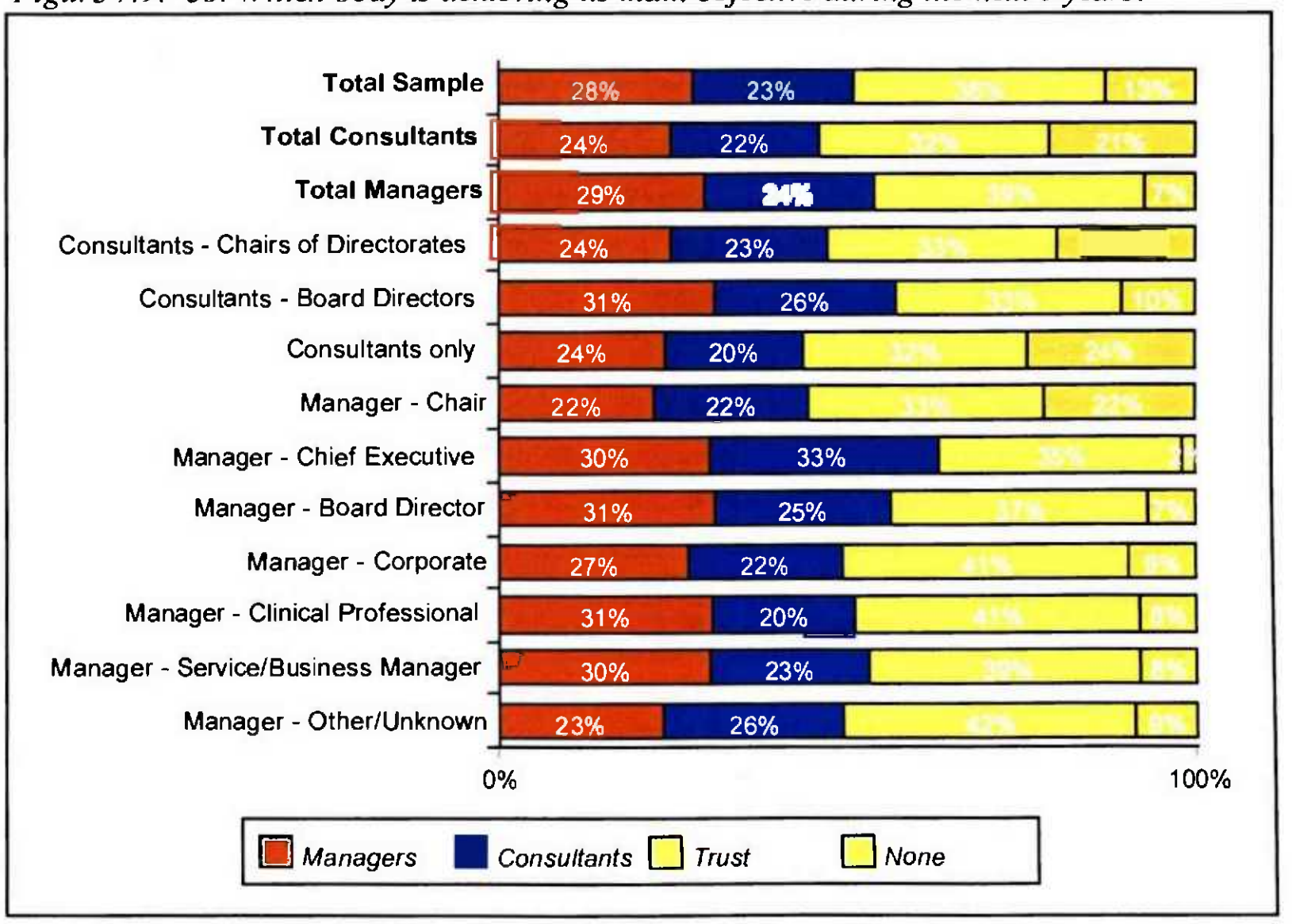
7.3.2 3b) Which body will achieve its main objective during the next three years?

The distribution of results is very similar to that in 3a above.

Table 7.12: 3b: Which body is achieving its main objective during the next 3 years?

		Managers	Consultants	Trust	None	Count	Sample	Ratio Count: Sample
a	**Total Sample**	724	617	954	336	2,631	1,577	1.7
b	**Total Consultants**	246	222	326	216	1,010	681	1.5
c	**Total Managers**	478	395	628	120	1,621	896	1.8
1	Consultants - Chairs of Directorates	124	118	166	102	510	330	1.5
2	Consultants - Board Directors	18	15	19	6	58	36	1.6
3	Consultants only	104	89	141	108	442	315	1.4
4	Manager - Chair	2	2	3	2	9	5	1.8
5	Manager - Chief Executive	49	53	57	3	162	73	2.2
6	Manager - Board Director	134	110	159	30	433	221	2.0
7	Manager - Corporate	63	52	96	22	233	131	1.8
8	Manager - Clinical Professional	38	25	51	10	124	81	1.5
9	Manager - Service/Business Manager	165	123	214	43	545	316	1.7
10	Manager - Other/Unknown	27	30	48	10	115	69	1.7

Figure 7.9: 3b: Which body is achieving its main objective during the next 3 years?

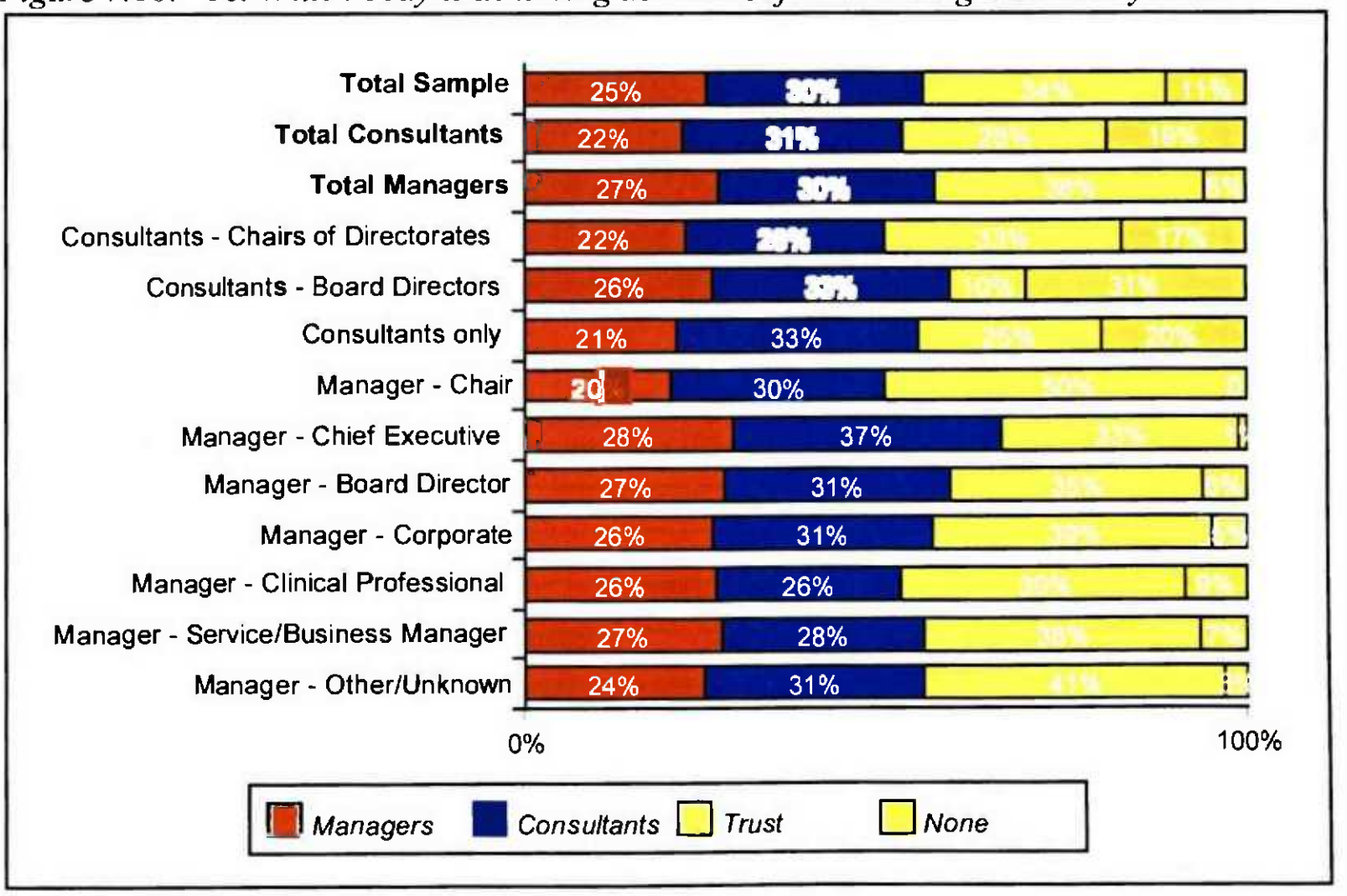


7.3.3 3c) Which body will achieve its main objective during the next six years?

Table 7.13: 3c: Which body is achieving its main objective during the next 6 years?

		Managers	Consultants	Trust	None	Count	Sample	Ratio Count: Sample
a	**Total Sample**	642	788	881	282	2,593	1,577	1.6
b	**Total Consultants**	216	303	281	193	993	681	1.5
c	**Total Managers**	426	485	600	89	1,600	896	1.8
1	Consultants - Chairs of Directorates	112	143	167	89	511	330	1.5
2	Consultants - Board Directors	15	19	6	18	58	36	1.6
3	Consultants only	89	141	108	86	424	315	1.3
4	Manager - Chair	2	3	5	0	10	5	2.0
5	Manager - Chief Executive	42	55	49	2	148	73	2.0
6	Manager - Board Director	110	127	143	24	404	221	1.8
7	Manager - Corporate	60	72	91	11	234	131	1.8
8	Manager - Clinical Professional	33	33	50	11	127	81	1.6
9	Manager - Service/Business Manager	149	157	211	37	554	316	1.8
10	Manager - Other/Unknown	30	38	51	4	123	69	1.8

Figure 7.10: 3c: Which body is achieving its main objective during the next 6 years?



Looking ahead six years there is a marked increase in the proportion of people who believe

that consultants will achieve their main objective over the period. The data suggests that all groups believe that consultants' aims will prevail over those of managers in the longer term (6 years) whereas in the short term managers' goals are regarded as dominant. Consultants, who tend to regard themselves as losing out against everybody (even against *None*) in Question 3a, see themselves as the dominant group ahead of the Trust in Year 6.

7.4 Question 4. How have priorities changed since the organisation became a Trust?

The majority of the sample felt that their own focus on priorities in the selected areas had become stronger, and a larger still majority believed that the Trust's priorities were being more vigorously pursued in these areas.

The graphs which follow summarise the frequency of ratings by doctors and managers. The tests used to examine the independence of doctors' and managers' responses produce almost identical results. The only area in which there was no significant difference between the answers of doctors and managers related to the Trust's attitude towards *financial break-even*. 83% of doctors and 79% of managers believed that this had strengthened as a Trust priority.

Figure 7.11: Total Sample - Changes in Priorities

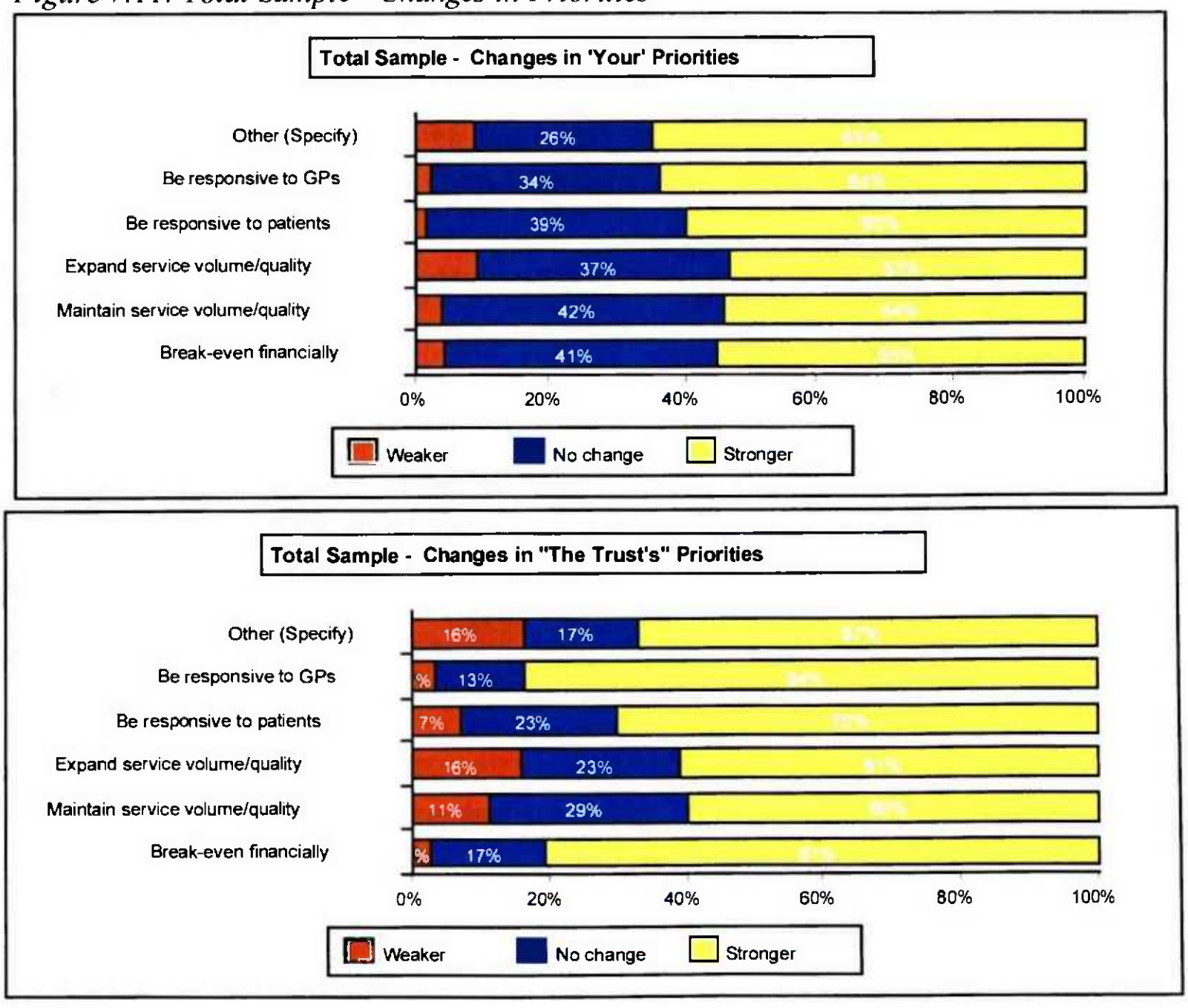
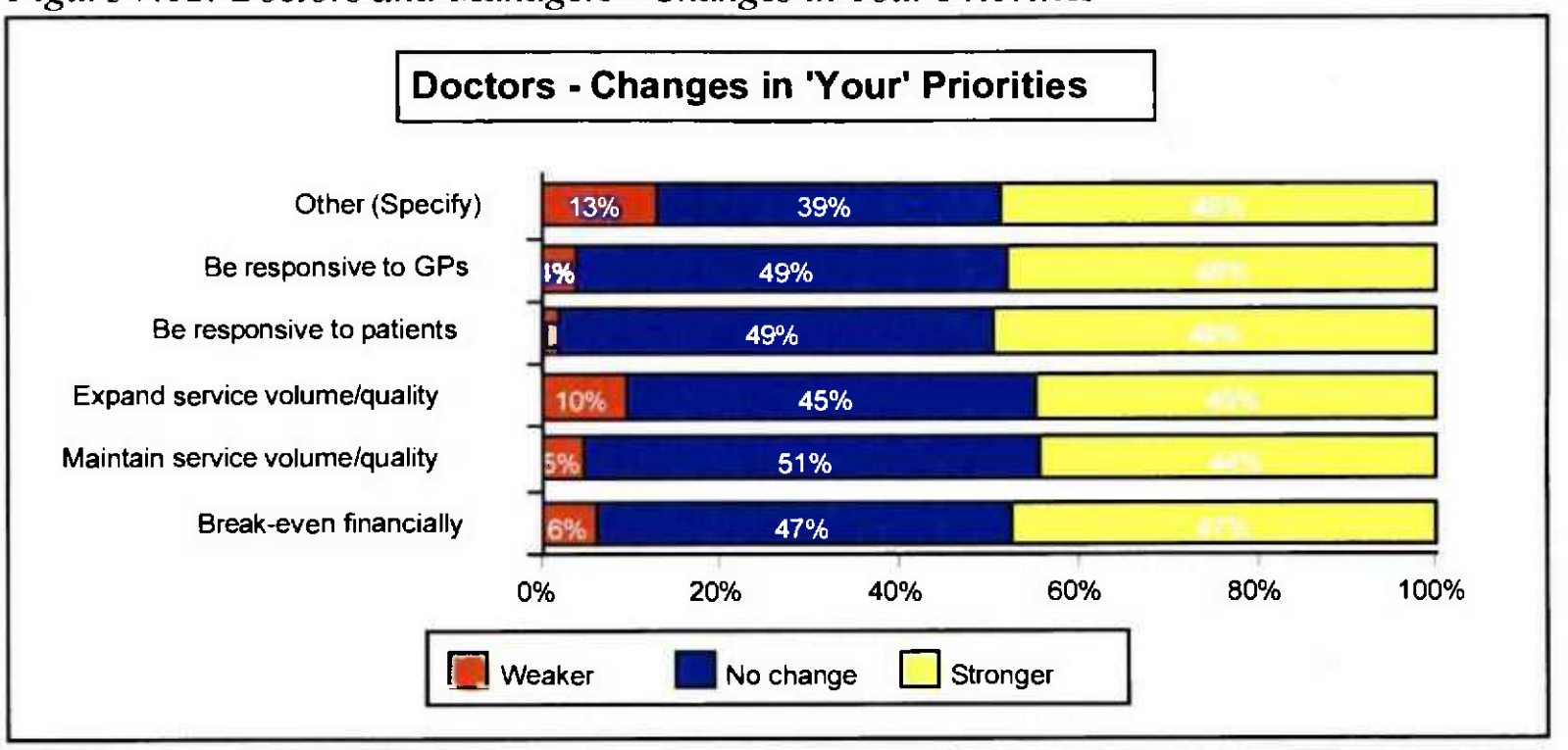


Figure 7.12: Doctors and Managers - Changes in Your Priorities



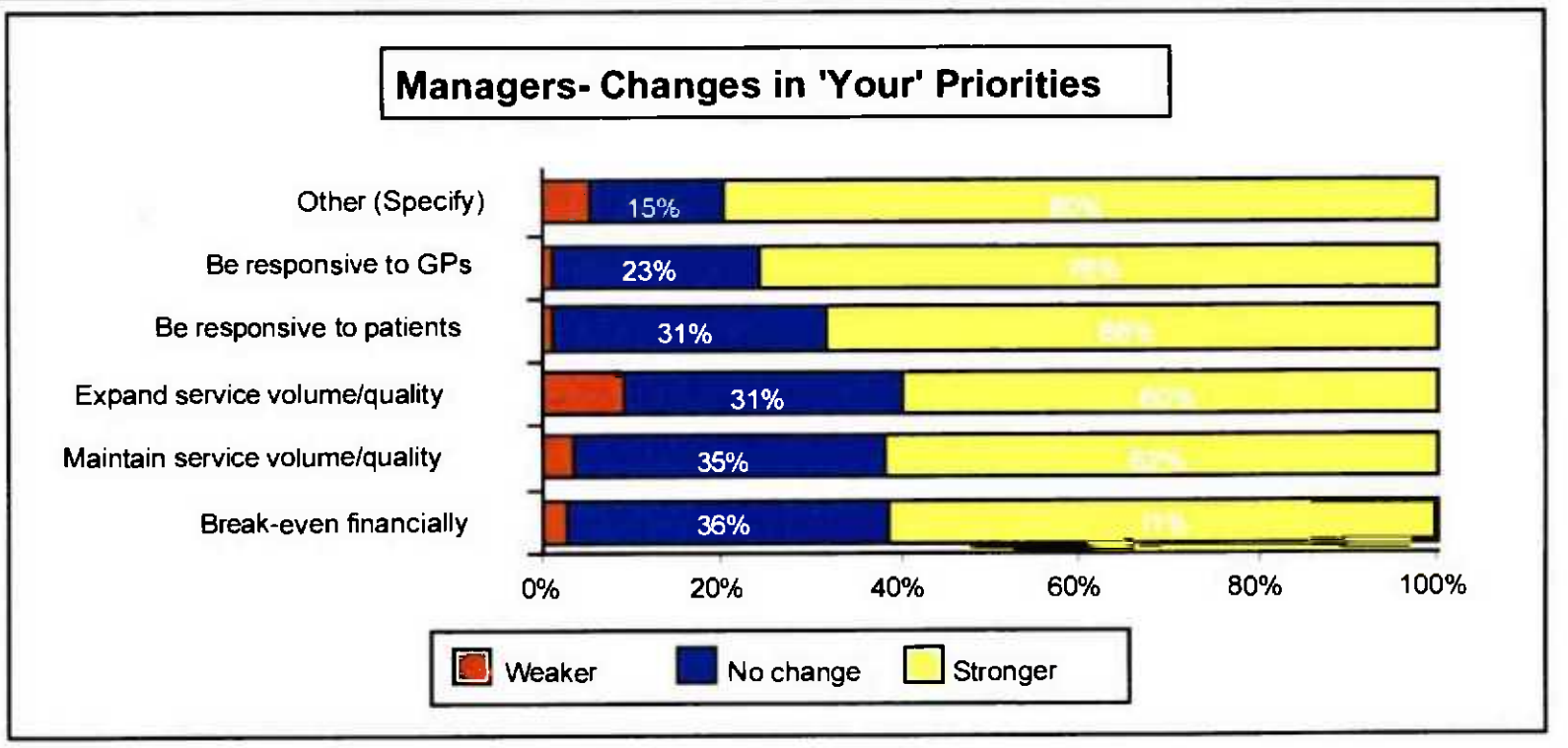


Figure 7.13: Doctors and Managers - Changes in the Trust's Priorities

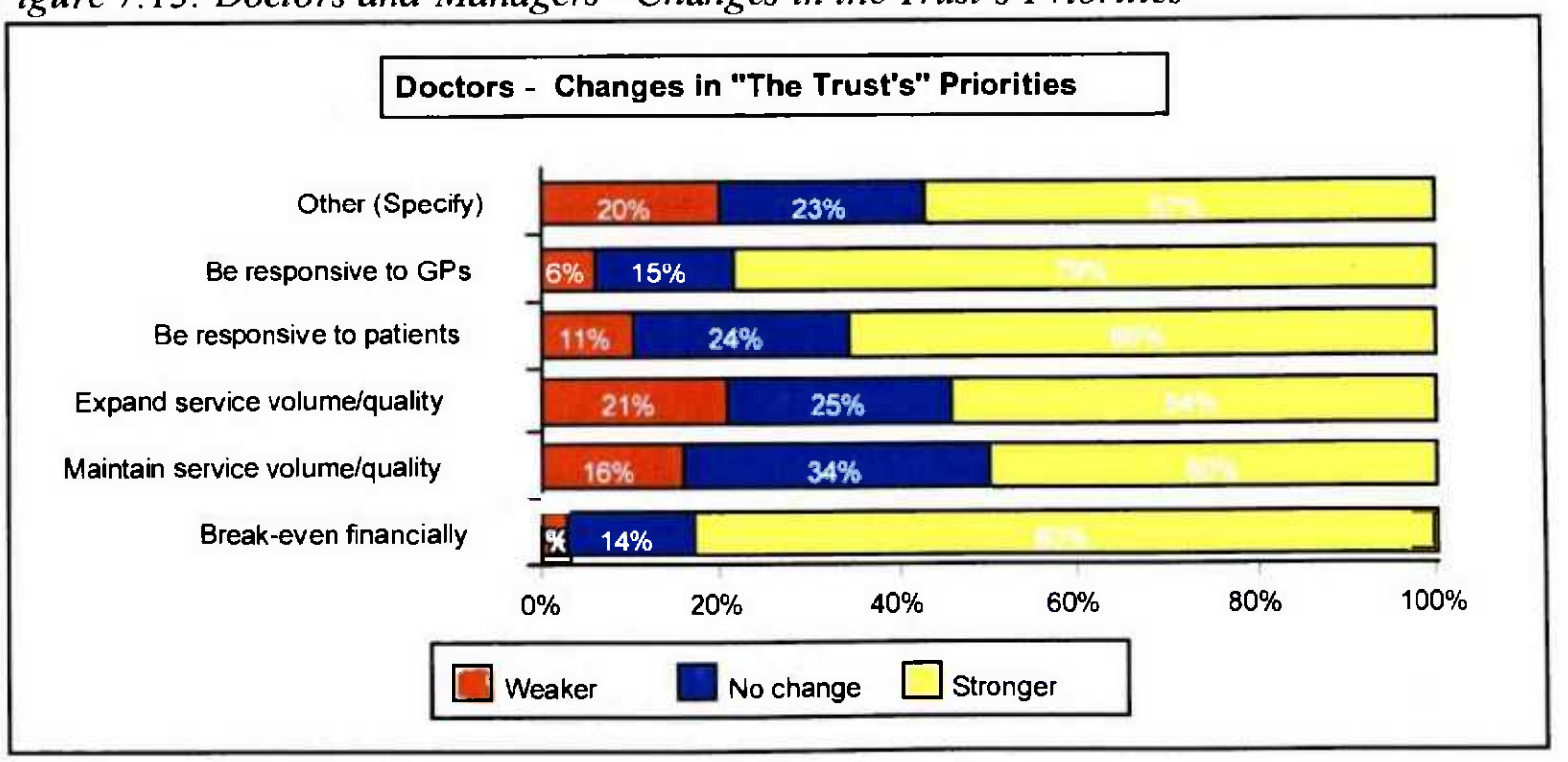
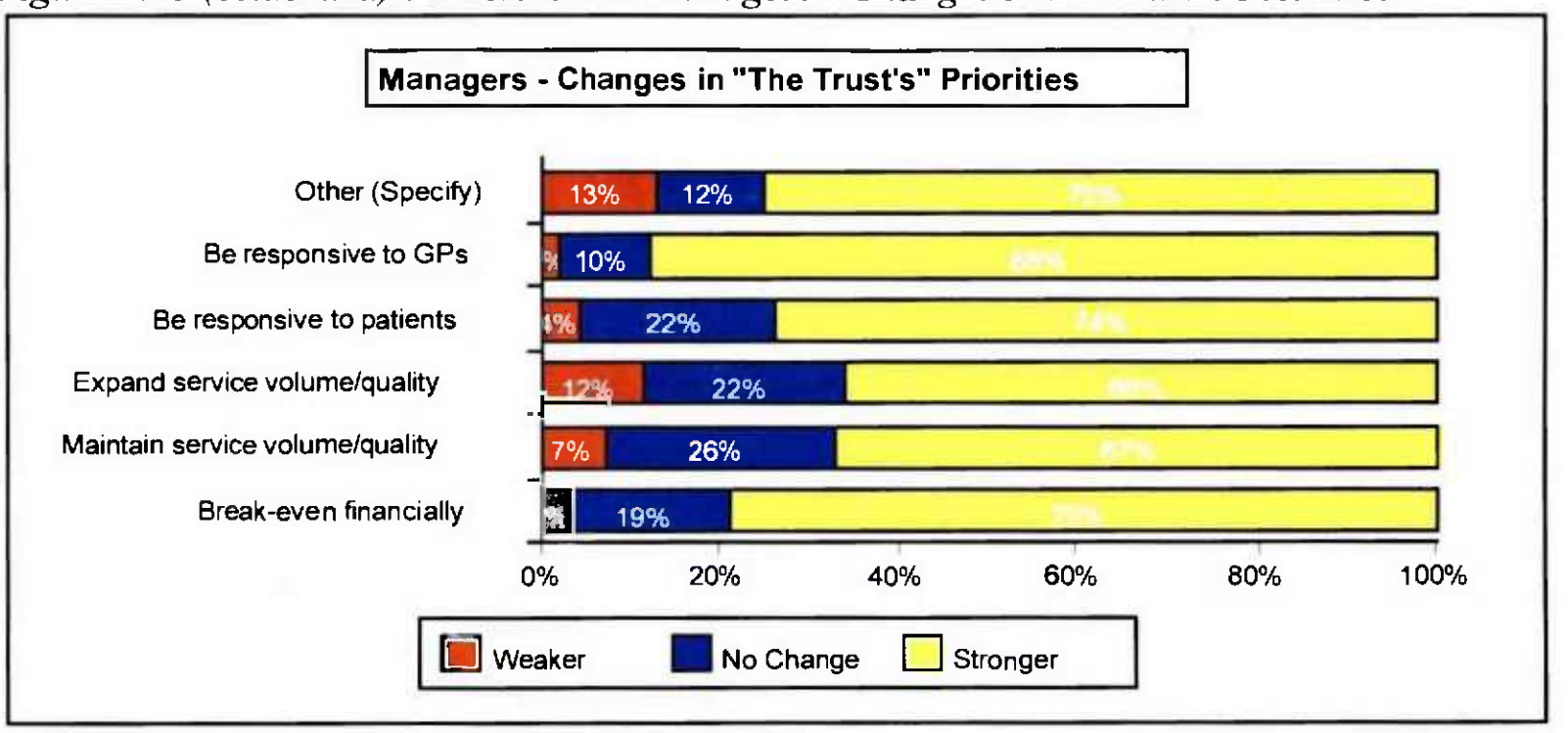


Figure 7.13 (continued) : Doctors and Managers - Changes in the Trust's Priorities



The tables below summarise the statistical tests run through SPSS and reduce the ratings frequencies into mean scores which are also depicted in graphical form. Doctors' ratings of every factor are, on average, below those of managers. The only exception is financial break-even as a Trust priority where doctors' ratings exceed the managers' scores although, as the statistical tests suggest, there is no significant difference in their responses for this category.

Table 7.14 : Tests of Significance Applied to Question 3

Doctors/Managers	*ANOVA*	*Pearson Chi Sq*
'Your' Priorities	p value	p value
Break-even financially	0	0
Maintain service volume/quality	0	0
Expand service volume/quality	0	0
Be responsive to patients	0	0
Be responsive to GPs	0	0
Other (Specify)	0.0001	0.00008
'Trust' Priorities		
Break-even financially	0.0777	0.09273
Maintain service volume/quality	0	0
Expand service volume/quality	0	0
Be responsive to patients	0	0
Be responsive to GPs	0	0
Other (Specify)	0.0361	0.04922

Table 7.15: Question 3 Mean Ratings

	Your Priorities				Trust's Priorities			
	Doctors	Manager	Sample	*Diff.*	Doctors	Managers	Sample	*Diff.*
Break-even financially	2.409	2.586	2.509	*-0.177*	2.804	2.76	2.779	*0.044*
Maintain service volume/quality	2.397	2.583	2.502	*-0.186*	2.339	2.598	2.486	*-0.259*
Expand service volume/quality	2.351	2.503	2.437	*-0.152*	2.332	2.545	2.453	*-0.213*
Be responsive to patients	2.469	2.671	2.583	*-0.202*	2.549	2.697	2.633	*-0.148*
Be responsive to GPs	2.438	2.746	2.612	*-0.308*	2.725	2.861	2.802	*-0.136*
Other (Specify)	2.349	2.742	2.557	*-0.393*	2.373	2.616	2.511	*-0.243*

Figure 7.14: Change in Your Priorities - Question 3

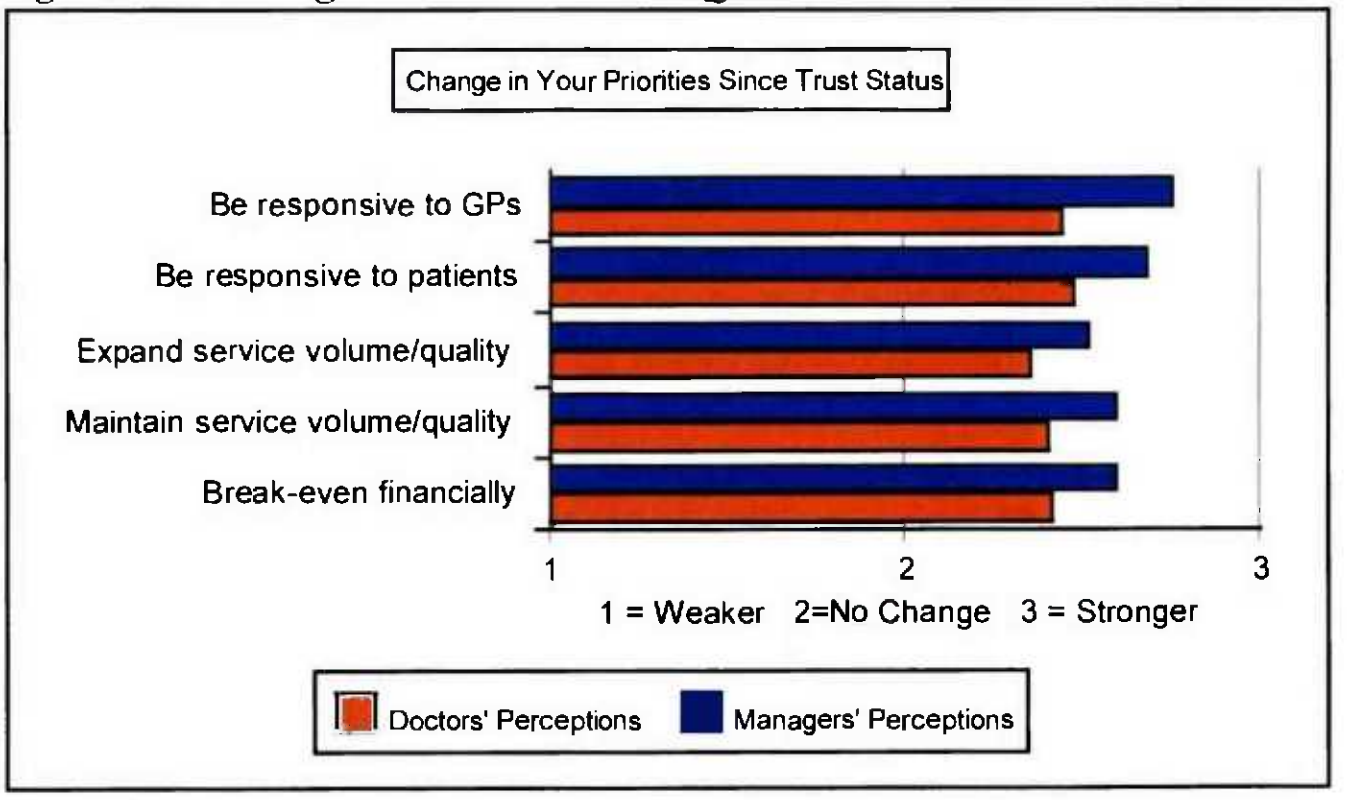
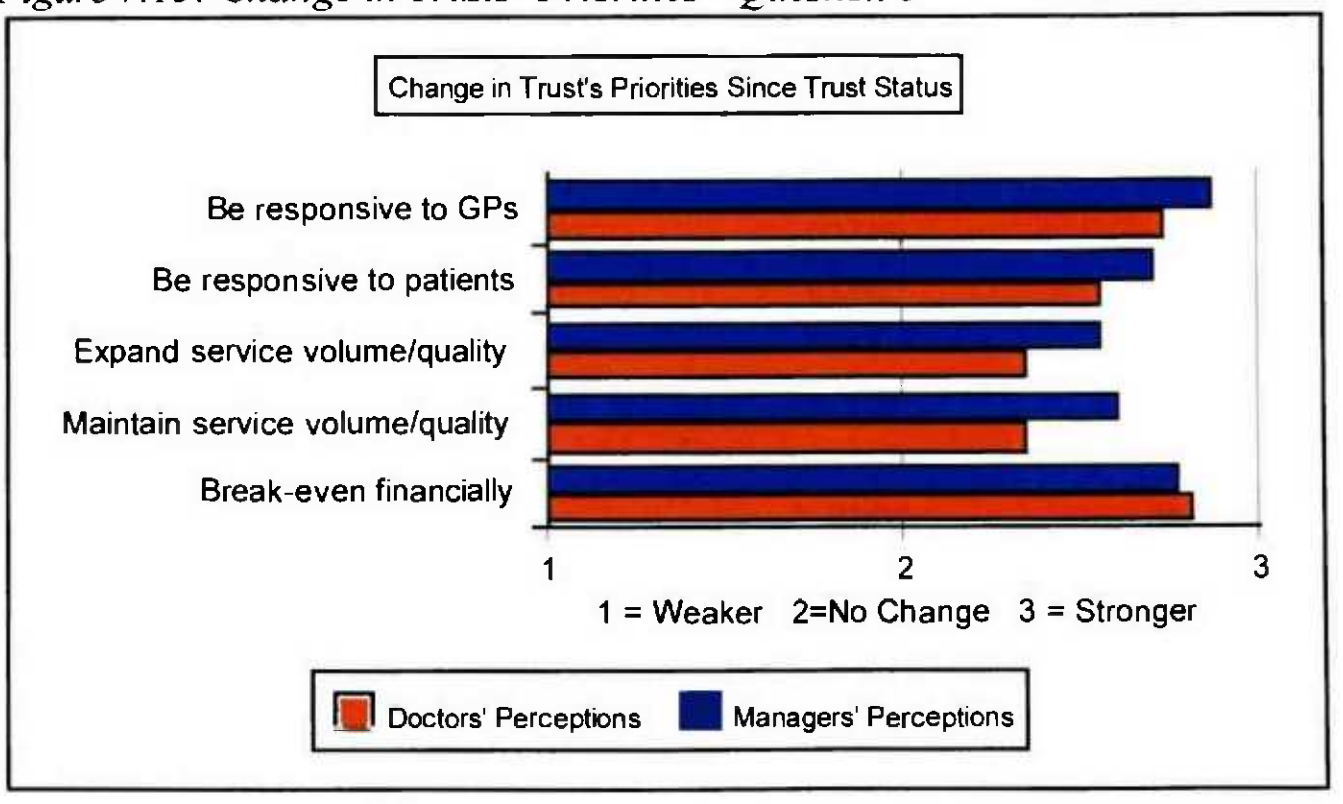


Figure 7.15: Change in Trusts' Priorities - Question 3



7.4.1 Differences Within the Doctor/Manager Groups

ANOVA was used to test the independence of groups within the doctor and manager categories. This test was selected on the basis that (a) the rating system satisfies the interval scale data structure required by ANOVA and (b) the preceding analysis indicates that for this data-set it produces the same results as non-parametric tests such as chi-squared.

The results are quite strong in suggesting that, while doctors and managers are independent groupings, there is no significant difference within the groupings in the way separate categories of doctors and managers answer the questions. The only exception to this relates to (4g), i.e. the answer by managers about financial break-even as a Trust priority.

The results below show that the grouping combinations behave independently once corporate managers (7) are added to the (4-6) grouping of Chair/CEO/Board Director. The remaining groupings of managers further down in the corporate structure show no significant internal difference. This sequence of tests led to (4-6) categories and (7-11) being recoded into two separate groups within the management category and the probability readings shown below highlight this as the significant break point within the management category.

This analysis of Question 4, therefore, highlights three distinct groupings within the Trusts which are independent from each other but internally consistent. These are (a) all doctors, (b) director level and above within the management group, and (c) all other managers which include corporate managers, clinical professional heads of service and service/business managers.

Table 7.16: Probability Results from ANOVA Test in Question 4

		Groups 1-3	Groups 4-11			
Question 4		**Doctors**	**Managers**			
Your Priorities		*ANOVA*	*ANOVA*			
a	Break-even financially	0.0067	0.0516			
b	Maintain service volume/quality	0.3158	0.1591			
c	Expand service volume/quality	0.8602	0.1565			
d	Be responsive to patients	0.2037	0.0660			
e	Be responsive to GPs	0.6363	0.2177			
f	Other (Specify)	0.6837	0.4982			
Trust's Priorities						*Groups*
g	Break-even financially	0.0620	**0.0000**	⇒	*0.0983*	*4-6*
h	Maintain service volume/quality	0.7524	0.8104		*0.0068*	*4-7*
j	Expand service volume/quality	0.4082	0.0955		*0.8358*	*7-8*
k	Be responsive to patients	0.0637	0.1836		*0.4751*	*7-11*
m	Be responsive to GPs	0.5770	0.5327		**0.0000**	**4/6 - 7/11**
n	Other (Specify)	0.7581	0.0998			

7.5 Question 5a. Since the change to Trust status, how has the relationship changed between consultants and managers?

70% of managers thought that there had been an improvement whereas less than half of doctors (48%) believed that relationships had improved. 14% of managers perceived a deterioration compared to 28% of doctors. The modal response in both groups was 'better'. This is a more optimistic assessment than the Hospital A pilot in which most consultants saw a deterioration whereas most managers believed that relationships had improved. At the same time, the national response indicates that managers take a more up-beat view of change than do the clinicians.

Table 7.17: Total Sample - Question 5a

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	36	*6%*	14	*2%*	50	*3%*	*4%*
2 Worse	143	*22%*	104	*12%*	247	*16%*	*10%*
3 No Change	157	*24%*	136	*16%*	293	*20%*	*8%*
4 Better	263	*40%*	462	*54%*	725	*48%*	*-14%*
5 Much Better	54	*8%*	135	*16%*	189	*13%*	*-8%*
Count	653	*100%*	851	*100%*	1504	*100%*	
Mean Rating	3.24		3.71		3.50		

Table 7.18: Consultants - Question 5a

	Clinical Chairs		Board Directors		Consultants Only		Consultant Total
1 Much Worse	10	*3%*	1	*3%*	25	*8%*	*36*
2 Worse	58	*18%*	5	*14%*	80	*27%*	*143*
3 No Change	84	*26%*	5	*14%*	68	*23%*	*157*
4 Better	140	*44%*	18	*52%*	105	*35%*	*263*
5 Much Better	27	*9%*	6	*17%*	21	*7%*	*54*
Count	319	*100%*	35	*100%*	299	*100%*	*653*
Mean Rating	3.36		3.66		3.06		

The consultant body shows differences between those with a management responsibility and those without. Progression up the management hierarchy from clinical consultants through Chairs of Clinical Directorates and up to Board Directors shows a progression in the proportions believing that relationships had improved and a diminution in those which feel that relationships have deteriorated. The modal response in each case continued to be 'better'.

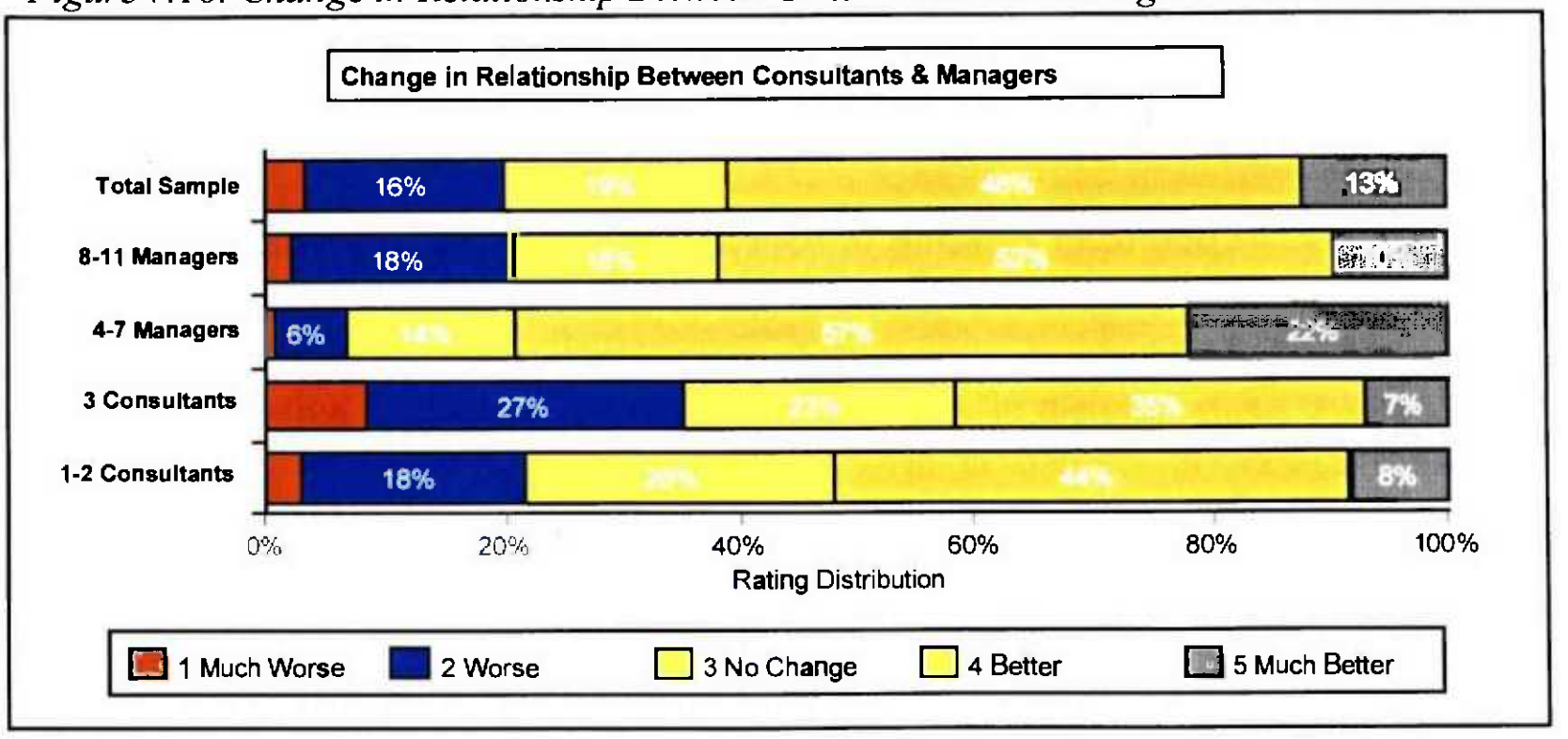
7.5.1 Degree of Independence Between & Within Categories of Respondents

Doctors and managers behave clearly as two independent groupings, according to the results of ANOVA tests. Within these categories it is necessary to consider different permutations to identify patterns of responses.

Table 7.19: ANOVA Results - Question 5a

Group	Description	ANOVA Probability
(1-3) - (4-11)	Whole Sample: Doctors/Managers	**0.0000**
Doctors		
1-3	Alll Doctors (Internally)	**0.0001**
1-2	Clinical Chairs/Board Directors	0.0943
2-3	Board Directors - Consultants	0.0025
(1+2) - 3	Chair/Board - Consultants	**0.0000**
Managers		
4 - 11	Managers (Internally)	**0.0000**
4 - 6	Chair/CEO/Board Director	0.0642
4 - 7	Ditto + Corporate Manager	**0.0092**
7 - 11	Corporate...Other	0.0167
8 - 11	Clinical Professional....Other	0.3728
9 - 11	Service/Business Mgr ....Other	0.9937
8 - 9	Clinical Prof./Service Mgr	0.0842
7 - 8	Corporate / Clinical Professional	**0.0008**
(4-7) - (8-11)		**0.0000**
(4-6) - (7-11)		**0.0000**

Figure 7.16: Change in Relationship Between Consultants and Managers - Score Distribution



Doctors

The data above shows that Clinical Chairs and Board Directors (1-2) do not reveal significantly different attitudes whereas Board Directors and Consultants (2-3) do. The grouping of Clinical Chairs/Board Directors into one category for comparison with Consultants shows the most significant difference in grouping (1&2 - 3). This suggests that consultants who do not have a position within the management structure of the Trust take a different view of trends in consultant/manager relationships to their colleagues. A larger number (although still a minority) believe that relationships have deteriorated. The responses to this question suggest a division in perceptions between the Trust-affiliated consultant body and the rest.

Managers

Chair/CEO/Board Director post-holders respond as a group (4-6) with no significant difference between them at the 1% level. The consistency of the sample weakens when we add Corporate managers (7), but at the 1% level (rounded) there is no significant difference within the grouping. The rest of the management cohorts do not display strong internal differences which leads to testing the structure of the management response by recoding individuals into two camps: corporate (4-7) and service (8-11). These two groupings behave as independent samples. The robustness of this conclusion is tested by incorporating group 7 (corporate managers) into the second group so that we have a distinction between Trust Directors and above (4-6) and the rest (7-11). This, too, suggests that the two groups behave as independent camps. The rogue category is therefore the Corporate Manager body which sits between the Trust group and the service group. This is consistent with the position of these individuals within the organisation because they have less service involvement and therefore less personal contact with consultants than clinical and service/business managers but, at the same time, do not have the seniority and Trust-affiliation of the CEO/Chair/ Director group.

7.6 Question 6a. How has the service to patients changed?

A similar relationship between consultants' and managers' views is reflected in this question to that of Question 5a, although there is a slight increase in the proportions of respondents who feel that the service has improved (compared to changes in manager/consultant relationships in Question 5). Again the modal response is 'better'.

Clinical Chairs are the most optimistic group of consultants, closely followed by consultants who are Board directors, i.e. Medical Directors. Consultants without these management responsibilities show a greater degree of pessimism with the largest proportion of the three groups declaring that services had deteriorated and less than half of the group indicating that services had improved. The table below sets out the details.

The battery of tests used for Question 5a was repeated for 6a with very similar results:

- Doctors and managers behave independently in their responses;
- Within the consultant group there is a significant distinction between Clinical Chairs/Board Directors on the one hand and Other Consultants on the the other;
- Managers can be divided into two independent groups: (i) Chair/CEO/Board Directors on the one hand and Corporate/Clinical/Service/Business Managers on the other.

Table 7.20: Total Sample - Question 6a

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	9	*1%*	9	*1%*	18	*1.2%*	*0%*
2 Worse	160	*25%*	87	*10%*	247	*17.0%*	*15%*
3 No Change	131	*20%*	112	*13%*	243	*16.1%*	*7%*
4 Better	315	*49%*	570	*67%*	885	*58.8%*	*-18%*
5 Much Better	36	*6%*	76	*9%*	112	*7.4%*	*-3%*
Count	651	*100%*	854	*100%*	1505	*100.0%*	
Mean Rating	3.32		3.72		3.55		

Table 7.21: Consultants - Question 6a

	Clinical Chairs		Board Directors		Consultants Only		Consultant Total
1 Much Worse	4	*1%*	0	*0%*	5	*2%*	*9*
2 Worse	66	*21%*	8	*23%*	86	*29%*	*160*
3 No Change	56	*17%*	7	*21%*	68	*23%*	*131*
4 Better	174	*54%*	17	*50%*	124	*42%*	*315*
5 Much Better	21	*7%*	2	*6%*	13	*4%*	*36*
Count	321	*100%*	34	*100%*	296	*100%*	*651*
Mean Rating	3.44		3.38		3.18		

Table 7.22: ANOVA Results - Question 6a

Group	Description	ANOVA Probability
(1-3) - (4-11)	Whole Sample: Doctors/Managers	**0.0000**
Doctors		
1-3	AIII Doctors (Internally)	**0.0028**
1-2	Clinical Chairs/Board Directors	0.7207
2-3	Board Directors - Consultants	0.2493
(1+2) - 3	Chair/Board - Consultants	**0.0007**
Managers		
4 - 11	Managers (Internally)	**0.0000**
4 - 6	Chair/CEO/Board Director	0.5198
4 - 7	Ditto + Corporate Manager	0.0194
7 - 11	Corporate...Other	0.0671
8 - 11	Clinical Professional....Other	0.0450
9 - 11	Service/Business Mgr ....Other	0.3429
8 - 9	Clinical Prof./Service Mgr	0.0316
7 - 8	Corporate / Clinical Professional	0.0315
(4-6) - (7-11)		**0.0000**

7.7 Question 7. Since the change to Trust status, do you think the goals of consultants have .....?

Moved closer together Not changed Moved further apart

The majority of respondents (61%) believed that the goals of consultants and managers had moved closer together while only 20% believed that they had moved further apart. Managers were more optimistic in their response than consultants, but the overall medical opinion reflects a convergence in goals. Within the consultant body the spread of opinion among non-board/chair consultants (group 3) was *44% closer : 22% no change : 34% further apart,* indicating that less than half the sample believed that goals had converged, but a smaller (though significant) proportion believed that the gap had widened. This contrasts with a spread of *56% closer : 20% no change : 24% further apart,* among their board/clinical chair colleagues.

Table 7.23: Total Sample - Question 7

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Moved closer together	331	*50%*	583	*69%*	914	*61%*	*-19%*
2 Not changed	136	*21%*	155	*18%*	291	*19%*	*3%*
3 Moved further apart	188	*29%*	114	*13%*	302	*20%*	*15%*
Count	655	*100%*	852	*100%*	1507	*100%*	
Mean Rating	1.78		1.45		1.59		

The ANOVA test of significance between the sample groups was repeated for Question 7 using the same structure as that employed for Questions 5a and 6a. The results are consistent with these earlier questions in that doctors and managers are two independent samples (ρ=0.0000). Within the consultant grouping, however, the results are weaker in that there is no significant difference at the 5% level between the three categories although, at the 5% level there is evidence of independence in the responses of board directors/chairs of clinical directorates and all other consultants (group 3). Managers can be divided into the distinct groupings of Chair/CEO/Board Director on the one hand and all other managers on the other.

Table 7.24: ANOVA Results - Question 7

Group	Description	ANOVA Probability
(1-3) - (4-11)	Whole Sample: Doctors/Managers	**0.0000**
Doctors		
1-3	Alll Doctors (Internally)	0.0802
1-2	Clinical Chairs/Board Directors	0.3822
2-3	Board Directors - Consultants	**0.0216**
(1+2) - 3	Chair/Board - Consultants	**0.0446**
Managers		
4 - 11	Managers (Internally)	**0.0000**
4 - 6	Chair/CEO/Board Director	0.8683
4 - 7	Ditto + Corporate Manager	0.5187
7 - 11	Corporate...Other	**0.0059**
8 - 11	Clinical Professional....Other	0.0583
9 - 11	Service/Business Mgr ....Other	0.3326
8 - 9	Clinical Prof./Service Mgr	**0.0376**
7 - 8	Corporate / Clinical Professional	**0.0004**
(4-6) - (7-11)		**0.0000**

7.7 Question 8. Which group, in your view, has the most control over the following aspects of service?

Table 7.25: Frequency Results of Question 8

Question 8. Which group, in your view, has the most control over the following aspects of service?

	Consultants	Nurses	Managers	Chief Executive	Trust Board	Purchasers	Other	Count
(a) Development of service								
Doctors	216	10	74	89	63	283	23	758
Managers	265	35	139	105	90	372	29	1035
Total	481	45	213	194	153	655	52	1793
(b) Availability of services (e.g. beds, theatres)								
Doctors	38	19	283	130	78	162	17	727
Managers	148	51	378	79	126	151	23	956
Total	186	70	661	209	204	313	40	1683
(c) Medical staffing levels								
Doctors	166	3	109	148	128	145	61	760
Managers	370	4	115	145	157	127	59	977
Total	536	7	224	293	285	272	120	1737
(d) Nurse staffing levels								
Doctors	8	122	329	82	88	93	18	740
Managers	12	203	466	61	140	98	33	1013
Total	20	325	795	143	228	191	51	1753
(e) Freedom to admit in-patient								
Doctors	507	17	74	9	9	69	8	693
Managers	722	36	93	10	9	57	22	949
Total	1229	53	167	19	18	126	30	1642
(f) Decision to treat patient								
Doctors	622	9	18	7	4	35	5	700
Managers	797	46	27	8	9	70	24	981
Total	1419	55	45	15	13	105	29	1681
Count for all categories								
Doctors	1557	180	887	465	370	787	132	4378
Managers	2314	375	1218	408	531	875	190	5911
Total	3871	555	2105	873	901	1662	322	10289
% Across All Categories								
Doctors	36%	4%	20%	11%	8%	18%	3%	100%
Managers	39%	6%	21%	7%	9%	15%	3%	100%
Total	37.6%	5.4%	20.5%	8.5%	8.8%	16.2%	3.1%	100%

Figure 7.17: Results of Question 8

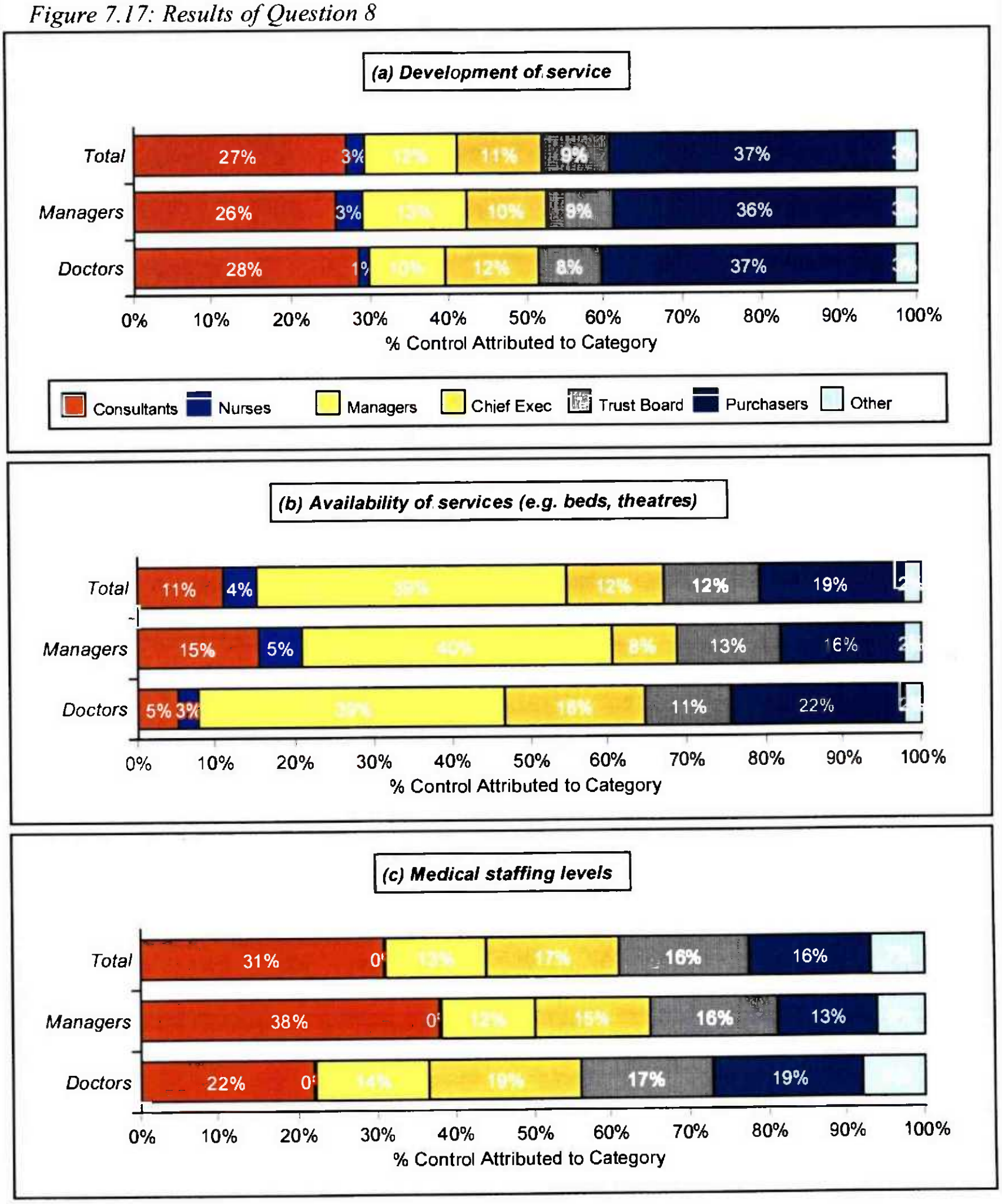
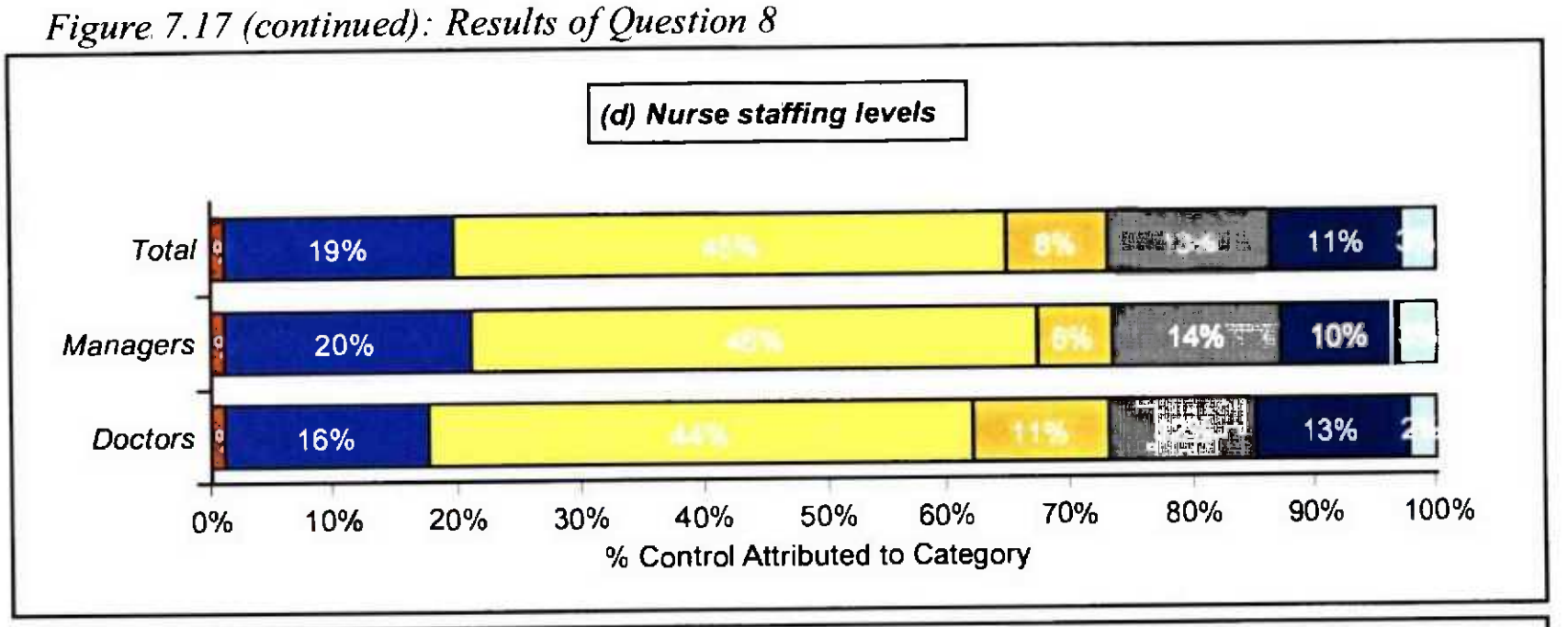
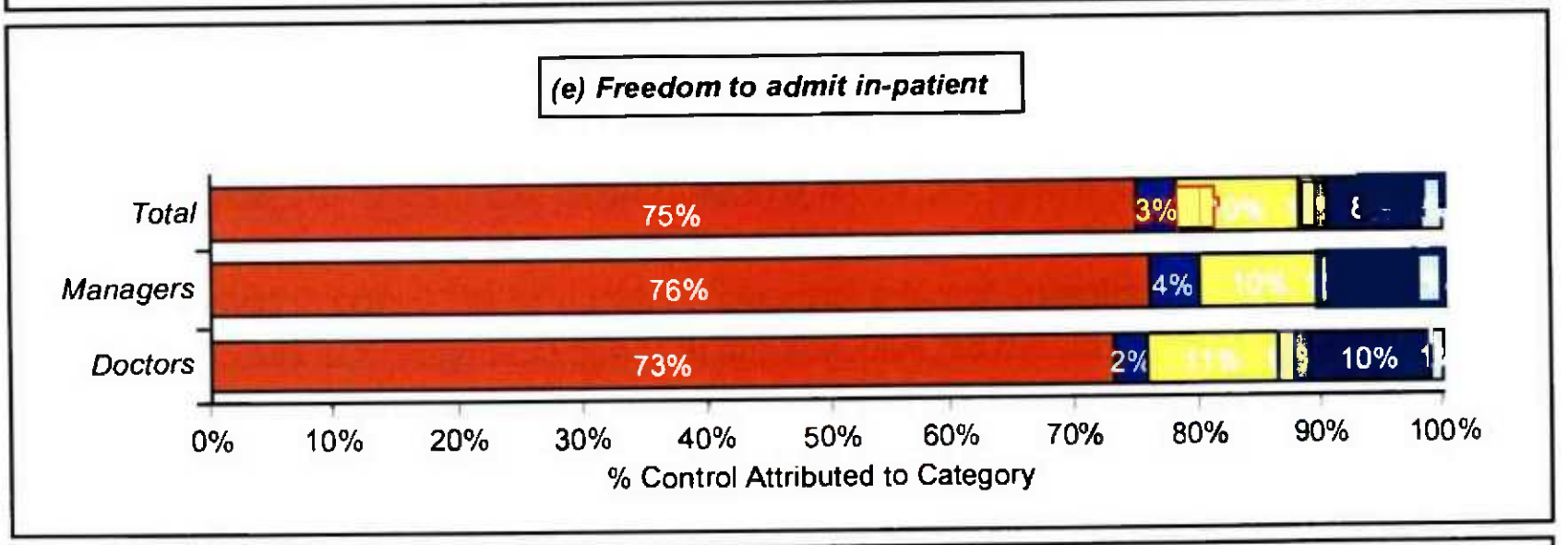
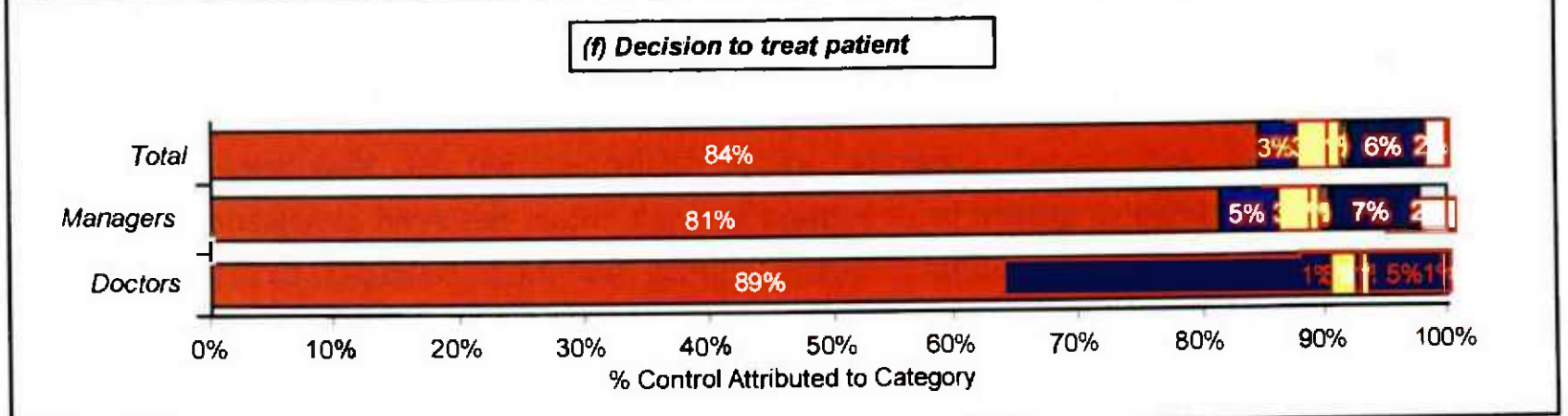
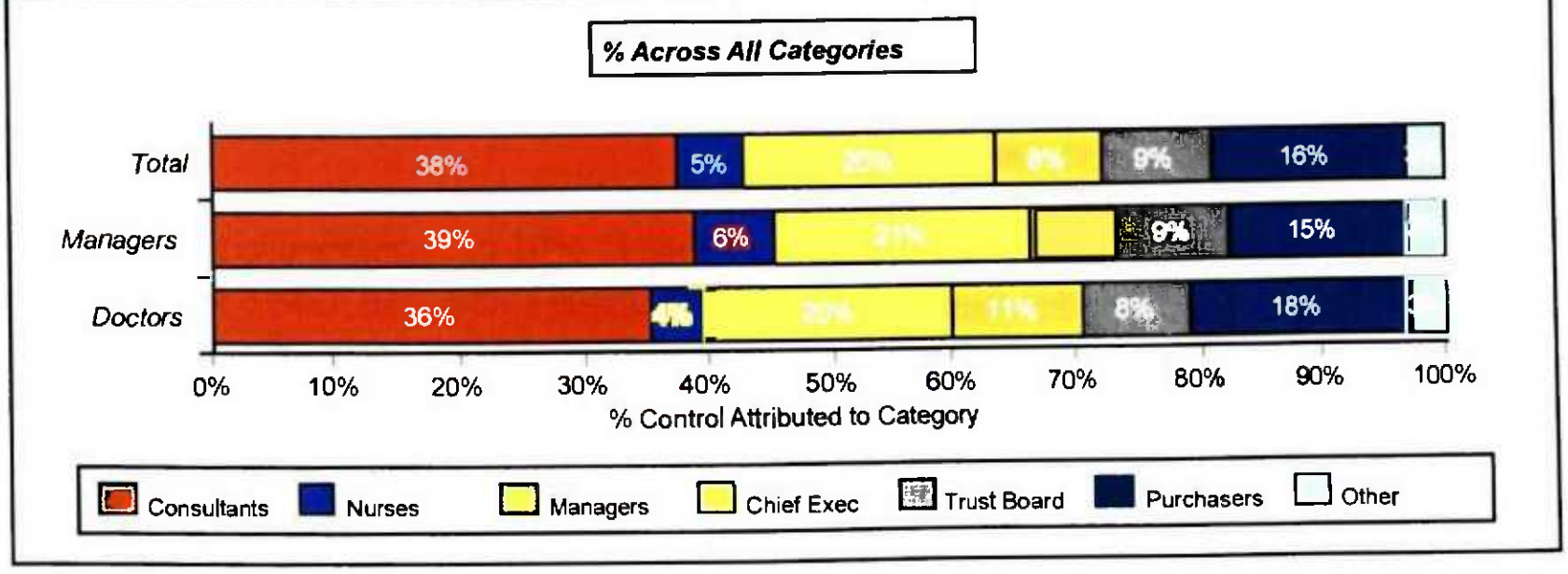


Figure 7.17 (continued): Results of Question 8









The responses show a high level of consistency in certain areas:

- **Development of the service** - doctors and managers produced a similar range of views. Purchasers are deemed by 37% of the sample to wield the most control, followed by consultants which received 26% of managers' votes and 28% of consultants'. The pattern of responses shows a coincidence of views between the two groups.

- **Availability of facilities** - both doctors and managers attribute 39%-40% of control over facilities such as beds and theatre to the management group. The main area of variation in views concerns the level of control held by consultants: 15% of managers' votes were directed to consultants as the main control-base whereas only 5% of doctors (i.e. consultants) thought that they held the most control over facilities.

- **Medical staffing levels** - Both groups believed that consultants have the most control in determining medical staffing levels, but there is a wide disparity in the level of control. Managers gave 38% of their vote to consultants as the main controllers whereas only 22% of doctors' responses selected consultants. Managers perceived doctors as having more power in this area than did the clinicians themselves.

- **Nurse staffing levels** - Again there was a high level of consistency between the groups' responses, each of whom identified managers as the main controlling body over nurse staffing levels, with a strong supplementary influence by nurses.

- **Freedom to admit in-patients** - doctors and managers attributed 73% and 76% respectively to the consultant body, showing consistency in their view that consultants have the major share of control in admitting in-patients to hospital. 10%-11% of responses from both groups attributed control to managers.

- **Decision to treat patients** - both doctors and managers believed that consultants have control over the decision to treat patients. Managers attributed 81% of control to consultants and 5% to nurses whereas doctors attributed 89% of their vote to consultants and only 1% to nurses.

- **Across all categories** - the voting patterns produce a consistent response between the two groups with 20%-21% of votes cast for managers, and an average of 38% cast for consultants, with a slightly higher perception of consultants' power in these areas being expressed by the management group. Doctors take a stronger view of the Chief Executive's discretion to control than do managers themselves. This discrepancy is expressed in terms of availability of facilities, medical staffing levels and nurse staffing levels.

On the basis of this response managers have the major control over service capacity in terms of facilities and nurse staffing levels. This is significant given that pay comprises over 70% of costs and the nursing budget is generally approximately 50% of the wage bill. Within the available capacity consultants are perceived as having control over admission and treatment of patients. Chief Executives and Trust Boards are perceived as wielding a lower level of direct control in most categories, although the aggregate control outweighs that of other groups in determining medical staffing levels.

This data can, on the one hand, be interpreted as a support for the view that doctors are responsible for decisions which account for 75% of expenditure, i.e. direct patient care costs as opposed to central overhead. However, it also indicates that doctors make those decisions to treat within a framework or set of constraints which are largely beyond their control in terms of beds and nurse staffing levels. The term 'managers' is distinguished here from the Chief Executive and Trust Board, and so is pitched at service/business manager level. According to this survey they have a high level of control over direct expenditure (i.e. the nursing budget) which is consistent with the directorate budget structure introduced in Trusts according to resource management principles. The question then concerns the motivation of this group of individuals. The aggregate result of this national survey suggests that budgetary control, taking an overall average, ranks highest among service/business managers' priorities and so, on this basis, Trusts should be in a strong position to balance the nursing workforce budget. The issue of quality or safety in nurse staffing levels would be an important consideration in meeting the budgetary constraint.

This analysis suggests that the pattern of views among service/business managers within Trusts could be decisive in determining the Trust's overall objective and performance.

7.8 Conclusion

The aim of this stage of the research programme is to test the hypothesis that doctors and managers are motivated by different and explicit goals. The results appear to confirm that this hypothesis is correct.

7.8.1 Motivation

Doctors on the whole conformed with each other as a group in the way they answered the questions. Managers also responded as a group but in important respects showed a distinction between the service and corporate ends of the spectrum. Specifically, service managers showed a greater service orientation in their responses, attaching a higher priority to quality of service than did the Board members and corporate managers. The response of service managers was more like that of consultants since *maintaining service quality* appeared to override *financial break-even* as the dominant objective, in terms of first-preference. This distinction bears out the assertion in Chapter 3 that 'managers' is a generic term applied to

different groups and functions; whereas very senior managers receive benefits to ensure that they identify closely with organisational goals, more junior managers do not receive such strong incentives. It also conforms with the Mintzberg typology in which top management has a role at the strategic apex, distinct from middle management located at the technostructure and the service managers supporting the operating core. Nevertheless, the first condition of 'difference between doctors and managers' underlying the hypotheses is satisfied by the consistency with which doctors and managers respond as two independent groups.

The second condition is that their motivation points in two different directions. Specifically, doctors are postulated to pursue service goals while managers overall aim to manage resources by balancing income (i.e. operating budget) and expenditure. This condition is, again, broadly satisfied. The hypotheses used the term 'service' loosely to mean a combination of quality and quantity. However, an unexpected result of this work is that quality is regarded by doctors as significantly more important than quantity. Managers fulfilled the hypothesis that financial break-even was a more important issue to them than either service quality or quantity. But the heterogeneity of managers, highlighted by this survey, cannot be overlooked and, to some extent, qualifies the results. The closer the proximity of managers to the operating core of Trusts, the closer do the views of managers resemble those of consultants. Quality is clearly the overriding factor among clinical service managers and could be interpreted as the dominant objective among service/business managers (although the mean ranking score favours break-even[23]). Since these managers have responsibility for resource management within the clinical directorate structure it could be argued that the overall management objective of financial break-even is fundamentally weakened by the attitudes of managers at the operating core.

This perspective is further supported by the attitude of all groups towards *the Trust* as an organisation. The results are striking in that nobody allied themselves with the Trust, which was perceived as aiming for financial targets above all else, with none of the equivocation between service and finance observed by many managers within their own aims. The projected aims of the Trust, therefore, are alien in tone to both doctors and managers alike. This would indicate a dichotomy between Trusts' perceived aims - which are consistent with statutory objectives - and their actual aims as revealed by the principal actors. If doctors are not at all interested in financial management and managers are interested but subject to tight constraints relating to quality then, unless managers - and senior executives at that - have a clear dominance within the Trust, the weight of probability is that the Trust will not be coherent in its objective of balancing the budget. Where service and financial objectives conflict the attitudinal data suggests that service goals will prevail. This is subjected to testing in Chapter 10.

[23] The mean score takes account of second and third preferences even though the first preference of service managers favoured maintenance of service quality.

7.8.2 Dominance

Evidence discussed in Chapter 3 indicated that doctors control the major part of resource allocation, e.g. Blumberg's assertion that 75% of expenditure is attributable to physicians (in Gray, 1001, p166). If this indicates the level of control exerted by doctors then it would appear that hospitals have a remote chance of meeting financial targets. The questionnaire is, however, designed to address this question of dominance and control within hospitals.

Answers to questions 4 - 7 indicate that the move to bring consultants into management and to achieve corporate identity through Trust status has been largely successful, although there is still no fundamental change in the orientation of doctors. Question 8, on the other hand, which deals with control of aspects of the production function shows that consultants' discretion to spend money is constrained by capacity limits set by managers in terms of the number of beds, theatres and nurse staffing levels. Doctors are perceived to have a major influence on medical staffing numbers and service developments, and they determine who is to be admitted to hospital and who is to be treated. But the decision to treat may be a deferred decision, amounting to an addition to the waiting list in surgical specialties where there are constraints on theatre or bed capacity. Nevertheless, doctors are resourceful and may find alternative means of achieving their service aims, e.g. by treating patients as day cases rather than inpatients, or as outpatients rather than day cases. This is dependent on availability of technology through service developments, e.g. more sophisticated anaesthetics with shorter recovery periods, and as such lie within the consultants' sphere of implementation.

Question 3 is an impressionistic question which seeks views on who is running the Trust by asking which groups are thought to be achieving their goals. The Trust is seen to be enjoying the most success in achieving its goals (Question 3a, Figure 7.8). This is consistent with the view that managers, who have the ability to rein in resources as described in Question 8, are perceived to be more successful than consultants in achieving their goals in the short term. If the objective of the Trust is financial balance (as agreed by both managers and clinicians in Question 2) then it is difficult to explain the response to this question in the long term (Question 3c, Figure 7.10) where the Trust is still seen as being the most successful body but consultants are seen as more successful than managers. One interpretation is that the goals of the Trust could be expected to come into line with those of doctors, using service developments (Question 8a) as a means of achieving this. These responses suggest that, in the end, doctors get the service developments they want, but that on a day to day basis they are constrained by funding.

7.8.3 Comparison with Stage 1

The results of the national survey are similar in many respects to those of the Stage 1 survey in Hospital A described in the previous chapter. Individual reputation was identified by

doctors and managers (Question 1) as the most important factor to their career. In the key Question 2, *break-even* was most important to managers (Question 2a) and *maintenance of quality* was most important to consultants (Question 2c) in both surveys, with consultants and managers behaving as two independent groups in both studies. The management group displayed internal tensions through the divergence in profile between service/business managers and their senior/corporate colleagues. Service/business managers showed a very strong interest in service delivery which, in the case of Hospital A, overrode the budgetary interest and, in the national sample, showed equivocation. (*Maintaining service quality* received more first preferences than *financial break-even* but the use of second preferences led to a higher mean ranking for *break-even* among this group).

The main difference between the two surveys lay in the mood of consultants, conveyed in Question 5, concerning the relationship between doctors and managers. Questions 3, 7 and 8 also reflect the disposition of consultants by asking who is achieving their objective, how patient services have changed and whether the goals of doctors and managers have converged. The results from Hospital A (Stage 1) showed a consultant workforce which felt that relationships had deteriorated, nobody was achieving their objective, doctors and managers had moved further apart in their goals and that the Chief Executive dominated the Trust. In the national survey (Stage 2), on the other hand, only a minority of consultants believed that relationships with managers had worsened. Most of them felt that the goals of doctors and managers had moved closer together. Like managers, they believed that the Trust was achieving its objectives in the short term (Question 3a) and that consultants controlled most of the service features listed in Question 8. Hospital A showed negative attitudes among consultants whereas the national sample was much more optimistic.

The contrast in the pattern of responses by consultants to these questions raised the possibility of a flaw, or strong bias, inherent in the sampling method which may have targeted two different types of consultants. A further stage was added to the questionnaire to test the validity of the national survey. This is the subject of the next chapter.

CHAPTER 8. QUESTIONNAIRE SURVEY: RESULTS OF STAGE 3 (CLOSED QUESTIONS)

Stage 3 of the questionnaire survey was introduced as a response to differences which emerged between the national sample (Stage 2) and the initial findings of the final pilot conducted in Hospital A as part of Stage 1. The evidence from Stage 1 indicated that managers and doctors had different perceptions of their own situation to the extent that managers thought that relationships with their consultant colleagues had markedly improved whereas the consultants believed that these same relationships had deteriorated since the advent of Trust status (Table 6.6). By contrast, both doctors and managers across the national sample believed by and large that relationships had improved, although the pattern of responses between the two groups was significantly different with a distinctly less upbeat note sounded by the clinicians (Table 7.17).

The possibility of truculent clinicians forming the sample in Hospital A compared to more manager-friendly consultants comprising the national sample posed a methodological problem relating to the way in which doctors had been selected. The Hospital A sample was composed of 20 consultants and 20 managers who were selected and contacted directly by the researcher. The national survey, in contrast, was administered through Chief Executive Officers who targeted half this number of consultants and managers per Trust. Each CEO received a pack of 20 questionnaires with an invitation to participate in the exercise and simple guidance which was restricted to a request to distribute the forms to 10 managers and 10 consultants. The smaller sample size and the difference in selection method provided potential bias in the national consultant sample on the basis that Chief Executives might tend to select their allies who were also engaged in management duties. While this potential problem was understood, it was judged on balance that extensive participation in the exercise was more important than bias due to sampling technique and that any complex instructions or reduction in CEOs' ability to select freely would reduce their participation rate. The questionnaire was designed to capture a measure of this potential bias through a description by each respondent of the amount of time spent on clinical and management duties. Stage 3 was then added to the process to mimic the sampling technique of Stage 1 and to assess the impact of differences in sample size and selection method between Stages 1 and 2. The CEO of Hospital B was, therefore, asked to distribute questionnaires to 40 individuals with a specific request to involve a cross-section of consultants.

The comparison of results is restricted to analysis of the closed questions.

8.1 Response Rate and Sample Description

Respondents were encouraged to describe themselves within one or more categories in order to capture clinical and management aspects of individuals' roles. The Hospital A and Hospital B respondents are compared with the national set:

Table 8.1: Respondent Categories

Hospital A Respondents		Hospital B Respondents		National	***Category***
18.2%	*4*	33.3%	*7*	20.9%	*1. Chair Clinical Directorates*
0.0%	*0*	4.8%	*1*	2.3%	*2. Board Director*
22.7%	*5*	33.3%	*7*	20.0%	*3. Consultants Only*
40.9%	**9**	**71.4%**	**15**	**43.2%**	**Total Consultants**
0.0%	*0*	0.0%	*0*	0.3%	*4. Chair*
4.5%	*1*	0.0%	*0*	4.6%	*5. CEO*
4.5%	*1*	4.8%	*1*	14.0%	*6. Board Director*
22.7%	*5*	9.5%	*2*	8.3%	*7. Corporate*
4.5%	*1*	4.8%	*1*	5.1%	*8. Clinical Professional*
18.2%	*4*	0.0%	*0*	20.0%	*9. Service/Business Manager*
4.5%	1	9.5%	2	3.9%	*10. Other Manager*
0.0%	0	0.0%	0	0.5%	*11. Unidentified*
59.1%	**13**	**28.6%**	**6**	**56.8%**	**Total Managers**
100.0%	*22*	100.0%	*21*	100.0%	
63%		32%		62%	% Management Time

The Hospital A survey was distributed to 40 individuals, 17 (43%) of whom were consultants and 23 (57%) who were managers. The overall response was 55% (22/40), comprising 9 (41%) consultants and 13 (59%) managers. The response rate for the national sample was also 55% with 43%:57% balance between doctors and managers, so that in this respect Hospital A typified the pattern across other Trusts. The overall Hospital B response rate was consistent with other Trusts at 53% (21/40) but the doctor:manager respondent ratio was 71%:29%. The sampling fears of 'management bias' in terms of consultant roles between the pilot and the national survey were ill-founded since the Hospital A response was typical of the national sample whereas Hospital B was more heavily weighted towards clinical staff. Likewise, the average managerial commitment within the Hospital A sample was consistent with the national sample whereas Hospital B's was half, in line with the high consultant representation.

8.2 Question 1. To what extent does your career depend on the following factors?

Hospital A and B samples did not differ significantly from each other in their responses to question 1 (on the basis of ANOVA tests) and they are broadly consistent with the national result. As hypothesised, *1g) survival of the Trust as an organisation* was markedly more important to managers than to doctors, in line with national results. The Trusts part company with the national sample on *1a) A financially successful Trust.* This was an area which showed the widest disparity between doctors and managers in the national study, where doctors attached little importance to this issue. In the Hospital B/Hospital A sample

both doctors and managers regard it as being moderately important.

The two main areas of difference between Hospital A and B Trusts lie in *1f) Standard of R&D and Teaching*, which Hospital B doctors perceive as unimportant, and *1h) Continued provision of the Trust's clinical service* which, again, Hospital B doctors rated consistently lower. This might indicate a less territorial attitude by Hospital B consultants and have a bearing on future behaviour since Hospital B Trust was expected to merge with a neighbouring Trust within twelve months of the survey period.

When the doctors and managers were considered separately between the two Trusts only two areas showed significant differences between the disciplines: *1c) Strength of the specialty/profession nationally* which, as one would expect, was more widely supported by doctors and *1f) Standard of R&D and Teaching* to which again doctors awarded greater importance.

Table 8.2: Mean Rating Scores on a Scale 1-5 where 1 is very low and 5 is very high

Total Sample	**1a**	**1b**	**1c**	**1d**	**1e**	**1f**	**1g**	**1h**	**1j**
National Sample Mean	3.42	3.97	3.41	4.19	3.62	3.08	3.68	4.02	4.35
Hospitals A & B Sample Mean	*3.24*	*3.81*	*3.41*	*4.40*	*3.70*	*2.85*	*3.63*	*3.95*	*4.25*
Point Difference	-0.18	-0.16	-0.00	0.21	0.08	-0.23	-0.05	-0.07	-0.10
Hospital B Mean	3.19	3.67	3.62	4.29	3.57	2.76	3.48	3.71	5.00
Hospital A Mean	3.30	3.95	3.20	4.52	3.86	2.95	3.77	4.18	3.50
Point Difference: Hospital A - Hospital B	0.11	0.28	-0.42	0.23	0.29	0.19	0.29	0.47	-1.50

Doctors	**1a**	**1b**	**1c**	**1d**	**1e**	**1f**	**1g**	**1h**	**1j**
National Doctors Mean	2.93	3.66	3.53	4.10	3.54	3.39	3.30	3.96	4.36
Hospitals A & B Sample Mean	*3.26*	*3.65*	*3.74*	*4.46*	*3.71*	*3.25*	*3.33*	*4.04*	*4.67*
Point Difference	0.33	-0.01	0.21	0.36	0.17	-0.14	0.04	0.08	0.31
Hospital B Mean	3.20	3.60	3.73	4.47	3.60	2.93	3.40	3.80	5.00
Hospital A Mean	3.38	3.75	3.75	4.44	3.89	3.78	3.22	4.44	4.00
Point Difference: Hospital A - Hospital B	0.18	0.15	0.02	-0.03	0.29	0.85	-0.18	0.64	-1.00

Managers	**1a**	**1b**	**1c**	**1d**	**1e**	**1f**	**1g**	**1h**	**1j**
Managers National Mean	3.80	4.21	3.32	4.27	3.68	2.84	3.98	4.07	4.34
Hospitals A & B Sample Mean	*3.22*	*4.00*	*3.00*	*4.33*	*3.74*	*2.29*	*4.00*	*3.84*	*3.00*
Point Difference	-0.58	-0.21	-0.32	0.06	0.06	-0.55	0.02	-0.23	-1.34
Hospital B Mean	3.17	3.83	3.33	3.83	3.50	2.33	3.67	3.50	
Hospital A Mean	3.25	4.08	2.83	4.58	3.85	2.27	4.15	4.00	
Point Difference: Hospital A - Hospital B	0.08	0.25	-0.50	0.75	0.35	-0.06	0.48	0.50	

8.3 Question 2. Within the Trust, how would you rank the priorities for the following sets of people?

Question 2 is the most important within the questionnaire and has been analysed extensively in earlier chapters. This section compares the response patterns of Hospitals A and B. (Appendix 2d provides detailed data and Appendix 4 summarises the results).

8.3.1 Hospital A and Hospital B Comparison

Break Even

The aggregated Hospital A/Hospital B rankings are very similar to those of the national sample in general. The strongest result in the national study was in the relative importance of *financial break-even* between doctors and managers. Managers saw it as the most important duty to themselves whereas consultants perceived it as being among the least important factors. This is mirrored in the case study results of Hospital A and Hospital B (2a), although Hospital A shows a lack of conviction in the financial objectives in relation to service/business managers generally (question 2h). Hospital B, on the other hand, revealed a more stringent managerial attitude to financial balance than either Hospital A or the national sample (comparing results of 2a, 2h, 2y) and seemed to regret this emphasis since managers took the view that the Trust 'ideally' should rank it last in importance.

Revenue Expansion

When we consider the two Trusts separately the main difference lies in their attitude to quality and to revenue expansion. Expansion of revenue and service volume is considered to be an important duty of service/business managers in Hospital B but much less so in Hospital A.

Hospital A is more like the national sample in its perception of revenue expansion and this links into the disenchantment with market mechanisms highlighted by the national survey. Hospital B is significantly different from both Hospital A and the national sample against this criterion and it suggests that a different set of messages are circulating within the Hospital B Trust, leading to a different order of objectives.

8.3.2 Comparison Between Consultant Groups

Doctors show a high level of consistency in their own priorities, both in the national comparison and within the internal check between Hospital B and Hospital A. Maintenance of service quality is their primary objective. They are also consistent in what they think the Trust's objectives should be 'ideally'. The main area of divergence lies in the Hospital B and Hospital A consultants' perceptions of their own Trust and of service/business managers. Both believe that the Trust pursues financial balance above other factors, but the Hospital A

consultants believe that maintenance and expansion of service quality is a much higher priority for the Trust than do the Hospital B doctors. Likewise, the Hospital A consultants believe that most service and business managers place a high emphasis on maintaining quality - coming second to break-even - whereas Hospital B's perception is that the managers give quality a low order of priority.

8.3.3 Comparison of Management Groupings

The national and Hospital A+B aggregated samples are closely aligned in terms of managers' views. They see break-even as their chief priority but in Hospital B the need to maintain service volume is considered to be equally important whereas in Hospital A this is less so, perhaps because Hospital A had historically exceeded its volume targets each year. Individuals in Hospital A believe that other business managers were mainly interested in maintaining volume, followed by maintaining quality and then, thirdly, in break-even; this shows a divergence in managers' view about themselves in Hospital A which is not reflected in the Hospital B or national sample.

Managers in Hospital B Trust believe that the consultant's main concern is expanding the volume of service provided. This is a plausible assumption which underpinned the original hypotheses about consultants' motivation. One of the surprising results of the survey has been the extent to which this is seen as a relatively low priority by doctors themselves. Hospital B diverges from Hospital A and the national sample in this management perception of consultants and Appendix 4 shows that consultants themselves do not regard volume targets as particularly important.

Hospital A and Hospital B managers' view of the Trust's current priorities show some differences in intensity, (e.g. higher scores are attributed by Hospital B to break-even and maintaining volume) but the overall ranking remains similar with break-even first and expanding quality seen as the least important to the Trust. Hospital A's view of the Trust's ideal priorities are similar to the national sample, with break-even placed first and expanding service volume ranked last overall. Hospital B managers, on the other hand, believe that the Trust should place maximum priority on expanding revenue, followed closely by volume expansion. The basic break-even objective is regarded as the least important in the Trust's ideal set of priorities.

8.3.4 Difference Between Consultants' and Managers' Perceptions

The strongest result in the Hospital A/Hospital B analysis of doctors and managers is consistent with the national sample, namely that doctors and managers have widely diverging views about the importance of financial break-even. Likewise, all groups show a high degree of consistency in their view of consultants' objectives and the pattern of responses in relation to the Trust is similar between the national and local study. Doctors believe that most

service/business managers pursue break-even more resolutely than do the managers themselves but in the Hospital A study the gap between doctors' and managers' perceptions is more marked.

8.4 Question 3. Which body is achieving its main objective?

Individuals were asked to tick against which body they believed was achieving its main objective at the moment. They were allowed to tick more than one from a choice of *Managers*, *Consultants*, *Trust* and *None*. This is an impressionistic question which was intended to convey the mood or attitudes of different groups.

Table 8.3: 3a: Which body is achieving its main objective at the moment?

	Managers	*Consultants*	*Trust*	*None*	*Count*	*Ratio Count: Sample*
National Figures						
a Total Sample	27%	22%	35%	16%	100%	1.6
b Total Consultants	24%	22%	30%	24%	100%	1.5
c Total Managers	29%	22%	38%	11%	100%	1.7
Hospital A						
a Total Sample	34%	21%	21%	24%	100%	1.5
b Total Consultants	20%	0%	10%	70%	100%	1.1
c Total Managers	40%	30%	26%	4%	100%	1.8
Hospital B						
a Total Sample	12%	16%	12%	60%	100%	1.2
b Total Consultants	11%	11%	11%	67%	100%	1.2
c Total Managers	14%	29%	14%	43%	100%	1.2

Table 8.4: 3b: Which body is achieving its main objective during the next three years?

	Managers	*Consultants*	*Trust*	*None*	*Count*	*Ratio Count: Sample*
National Figures						
a Total Sample	28%	23%	36%	13%	100%	1.7
b Total Consultants	25%	22%	32%	21%	100%	1.5
c Total Managers	30%	24%	39%	7%	100%	1.8
Hospital A						
a Total Sample	21%	21%	30%	28%	100%	1.3
b Total Consultants	0%	11%	11%	78%	100%	1.0
c Total Managers	30%	25%	40%	5%	100%	1.5
Hospital B						
a Total Sample	25%	14%	32%	29%	100%	1.3
b Total Consultants	25%	10%	30%	35%	100%	1.3
c Total Managers	25%	25%	37%	13%	100%	1.3

Table 8.5: 3c: Which body is achieving its main objective during the next six years?

	Managers	Consultants	Trust	None		Ratio Count: Sample
National Figures						
a **Total Sample**	25%	30%	34%	11%	100%	1.6
b **Total Consultants**	22%	31%	28%	19%	100%	1.5
c **Total Managers**	27%	30%	37%	6%	100%	1.8
Hospital A						
a **Total Sample**	16%	32%	32%	20%	100%	1.4
b **Total Consultants**	0%	33%	22%	45%	100%	1.0
c **Total Managers**	23%	32%	36%	9%	100%	1.7
Hospital B						
a **Total Sample**	29%	18%	24%	29%	100%	1.3
b **Total Consultants**	25%	15%	25%	35%	100%	1.3
c **Total Managers**	37%	25%	25%	13%	100%	1.3

The national sample showed that consultants and managers each believed that the Trust was achieving its objectives at the moment to a greater extent than either consultants as a group or managers. Both groups also believed that managers were achieving their objectives to a greater extent than consultants. The main divergence in the national sample lay in the proportion who thought that 'nobody' was achieving their objective: 24% of consultants took this pessimistic view compared to 11% of managers.

The Hospital B and Hospital A samples behaved rather differently from the national sample. Two thirds of consultants in both Hospital A and Hospital B believed that nobody was currently achieving their objective. A large proportion of Hospital B managers (43%) also took this view whereas managers in Hospital A appeared to be very up-beat since only one person (4% of count) believed that nobody was achieving their goal while the highest vote (40%) went to managers themselves. None of the consultants in the Hospital A sample and only 11% in the Hospital B sample believed that consultants were achieving their aim. In summary, the majority view nationally was that *the Trust* was achieving its aim now whereas in Hospital B *nobody* was believed to be winning and in Hospital A *managers* were seen to be achieving their goals overall.

Asking the same question over a three year period produced little shift in the national response where the Trust was still perceived to be dominant by most groups. Hospital B respondents shifted markedly to take the same overall view that the Trust would dominate, although the consultant vote (35%) still reflected a view that nobody would achieve their aim and that consultants (10%) themselves would be the least successful group. The overall Hospital A vote reflected the view that influence would shift away from managers and that the Trust would dominate. The consultants maintained their view that nobody would achieve their aims.

Over a six year period there was a perception that consultants would increase their level of control. In the national sample consultants believed that they themselves would be more successful than the Trust in achieving objectives. This was not echoed by the Hospital B survey in which consultants felt they would be the weakest group and managers believed that influence would shift towards managers while consultants still believed in the main that nobody would achieve their aim. Hospital A consultants likewise believed that nobody would dominate (45%) although they perceived a shift in their favour. Hospital A managers believed that the Trust would be the strongest body with the balance between managers and consultants reversing in the consultants' favour. Both Hospital A and the national sample envisaged a shift of power from managers to consultants over six years but Hospital B reflected a view that in the longer term either managers or nobody would be the most successful group.

The overall impression is that Hospital A managers feel that they have a degree of control at the moment but that in the longer term they will lose it. Managers in Hospital B at the moment appear to feel powerless but take the view that given time they will gain control. Consultants in both sites are cynical or pessimistic in their view that nobody will get what they want, even over six years, but Hospital A consultants rate their chances above those of the managers. Both Hospital A and Hospital B are more pessimistic than the national sample since a high proportion believe that nobody will achieve their goal.

8.5 Question 4. How have priorities changed since Trust status?

Respondents were asked to rate how their own priorities had changed since Trust status and were asked to take a view on how the Trust priorities had changed during the same period. This question considers dynamic changes in objectives rather than providing a snapshot of current rankings as in Question 2.

In the national sample doctors felt that all their objectives had strengthened, with particular emphasis on being responsive to patients and being responsive to GPs. They also believed that break-even had become more important to them as a priority. This suggests that, though it ranked last in Question 2, it would have been even less important prior to Trust status. Managers also gave these two factors the highest rating in terms of strengthened priorities. Both groups believed that the Trust's objectives had become even stronger in all the areas listed, but consultants identified *financial break-even* as the area where Trust priorities had strengthened most, followed by being responsive to GPs. Managers also selected these as the two areas where Trust priorities had most changed but gave highest rating to ***responsiveness to GPs***. The Hospital A response was consistent with the national sample while Hospital B was more idiosyncratic: consultants believed that their own priority of expanding service volume/quality had strengthened most whereas managers believed that on the whole their own priorities had not changed but were unanimous in believing that responsiveness to GPs had become stronger as a priority.

Table 8.6: Response to Question 4

Mean Scores: Extent of Change where 1 = Weaker, 2 = No Change and 3 = Stronger

National Sample	Your Priorities				Trust's Priorities			
	Doctors	Manager	Sample	*Diff.*	Doctors	Managers	Sample	*Diff.*
Break-even financially	2.409	2.586	2.509	*-0.177*	2.804	2.760	2.779	*0.044*
Maintain service volume/quality	2.397	2.583	2.502	*-0.186*	2.339	2.598	2.486	*-0.259*
Expand service volume/quality	2.351	2.503	2.437	*-0.152*	2.332	2.545	2.453	*-0.213*
Be responsive to patients	2.469	2.671	2.583	*-0.202*	2.549	2.697	2.633	*-0.148*
Be responsive to GPs	2.438	2.746	2.612	*-0.308*	2.725	2.861	2.802	*-0.136*

Hospital A	Your Priorities				Trust's Priorities			
	Doctors	Manager	Sample	*Diff.*	Doctors	Managers	Sample	*Diff.*
Break-even financially	2.220	2.620	2.450	*-0.400*	2.780	2.850	2.820	*-0.070*
Maintain service volume/quality	2.440	2.310	2.360	*0.130*	2.130	2.150	2.140	*-0.020*
Expand service volume/quality	2.330	2.540	2.450	*-0.210*	2.330	2.620	2.500	*-0.290*
Be responsive to patients	2.560	2.850	2.730	*-0.290*	2.220	2.850	2.590	*-0.630*
Be responsive to GPs	2.500	2.690	2.620	*-0.190*	2.440	3.000	2.770	*-0.560*

Hospital B	Your Priorities				Trust's Priorities			
	Doctors	Manager	Sample	*Diff.*	Doctors	Managers	Sample	*Diff.*
Break-even financially	2.470	2.200	2.400	*0.270*	3.000	2.330	2.810	*0.670*
Maintain service volume/quality	2.330	2.000	2.250	*0.330*	2.000	2.330	2.100	*-0.330*
Expand service volume/quality	2.730	2.000	2.550	*0.730*	2.400	2.330	2.380	*0.070*
Be responsive to patients	2.600	2.000	2.450	*0.600*	2.600	2.170	2.480	*0.430*
Be responsive to GPs	2.470	3.000	2.580	*-0.530*	2.800	3.000	2.860	*-0.200*

8.6 Question 5a. Since the change to Trust status, how has the relationship changed between consultants and managers?

Consultants and managers were asked to rate whether they thought the relationship between the two groups had deteriorated or improved over the period. In the national sample 70% of managers thought that there had been an improvement in consultant/manager relationships whereas less than half of doctors (48%) believed that relationships had improved. 14% of managers perceived a deterioration compared to 28% of doctors. The modal response in both groups was 'better'. This is a far more optimistic assessment than Hospital A where 76% of consultants thought that relationships between the two groups had deteriorated, whereas none of the managers believed that relationships had deteriorated and 92% believed that they had improved.

In the Hospital B sample a different picture emerged. The majority of consultants (60%) believed that relationships with managers had improved and, in line with the national sample, only 27% believed that relationships had deteriorated. Managers in Hospital B were more

pessimistic than their consultants and more pessimistic than the national sample since less than half believed that relationships had improved. This may be related to the perception in Question 3 that consultants are achieving their own objectives to a greater extent than managers, suggesting a feeling of powerlessness on the part of managers.

Table 8.7: Results of Question 5a

National	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	36	*6%*	14	*2%*	50	*3%*	*4%*
2 Worse	143	*22%*	104	*12%*	247	*16%*	*10%*
3 No Change	157	*24%*	134	*16%*	291	*20%*	*8%*
4 Better	263	*40%*	462	*54%*	725	*48%*	*-14%*
5 Much Better	54	*8%*	135	*16%*	189	*13%*	*-8%*
Count	653	*100%*	849	*100%*	1502	*100%*	
Mean Rating	3.24		3.71		3.50		

Hospital A	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	1	*12.5%*	0	*0.0%*	1	*4.8%*	*13%*
2 Worse	5	*62.5%*		*0.0%*	5	*23.8%*	*63%*
3 No Change	1	*12.5%*	1	*7.7%*	2	*9.5%*	*5%*
4 Better	1	*12.5%*	8	*61.5%*	9	*42.9%*	*-49%*
5 Much Better	0	*0.0%*	4	*30.8%*	4	*19.0%*	*-31%*
Count	8	*100%*	13	*100%*	21	*100%*	
Mean Rating	2.25		4.23		3.48		

Hospital B	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	1	*6.7%*	0	*0.0%*	1	*5.0%*	*7%*
2 Worse	3	*20.0%*	1	*20.0%*	4	*20.0%*	*0%*
3 No Change	2	*13.3%*	2	*40.0%*	4	*20.0%*	*-27%*
4 Better	8	*53.3%*	1	*20.0%*	9	*45.0%*	*33%*
5 Much Better	1	*6.7%*	1	*20.0%*	2	*10.0%*	*-13%*
Count	15	*100%*	5	*100%*	20	*100%*	
Mean Rating	3.33		3.40		3.35		

These results indicate that the sampling method did not account for the difference between the Hospital A and national surveys since the Hospital B sampling approach mimicked that of Hospital A to a large extent. It was Hospital A's extreme response to this question which had prompted a detailed comparison with another Trust to test the impact of sample size and selection procedure.

8.7 Question 6a. Since the change to Trust status, how has the service to patients changed?

Consultants and managers were asked to rate whether they thought the service to patients had deteriorated or improved over the period.

Table 8.8: Results of Question 6a

National	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	9	*1%*	9	*1%*	18	*1%*	*0%*
2 Worse	160	*25%*	87	*10%*	247	*17%*	*14%*
3 No Change	131	*20%*	112	*13%*	243	*16%*	*7%*
4 Better	315	*48%*	570	*67%*	885	*59%*	*-18%*
5 Much Better	36	*6%*	76	*9%*	112	*7%*	*-3%*
Count	651	*100%*	854	*100%*	1505	*100%*	
Mean Rating	3.32		3.72		3.55		

Hospital A	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	2	*25.0%*	0	*0.0%*	2	*10.0%*	*25%*
2 Worse	1	*12.5%*	0	*0.0%*	1	*5.0%*	*13%*
3 No Change	3	*37.5%*	2	*16.7%*	5	*25.0%*	*21%*
4 Better	2	*25.0%*	8	*66.7%*	10	*50.0%*	*-42%*
5 Much Better	0	*0.0%*	2	*16.7%*	2	*10.0%*	*-17%*
Count	8	*100%*	12	*100%*	20	*100%*	
Mean Rating	2.63		4.00		3.45		

Hospital B	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Much Worse	1	*7%*	0	*0%*	1	*5%*	*7%*
2 Worse	2	*13%*	3	*50%*	5	*24%*	*-37%*
3 No Change	3	*20%*	0	*0%*	3	*14%*	*20%*
4 Better	7	*47%*	3	*50%*	10	*48%*	*-3%*
5 Much Better	2	*13%*	0	*0%*	2	*10%*	*13%*
Count	15	*100%*	6	*100%*	21	*100%*	
Mean Rating	3.47		3.00		3.33		

All sample groups responded that they believed services to patients had improved, with the exception of Hospital A consultants who on average believed that services had deteriorated.

8.8 Question 7. Since the change to Trust status, do you think the goals of consultants and managers have .....?

Moved closer together **Not changed** **Moved further apart**

The majority of all respondents in the national sample believed that the goals of managers and consultants had moved closer together. Managers in Hospital A and Hospital B also believed that objectives had converged. The majority of consultants in both hospitals, however, believed that goals had moved further apart. The Hospital A consultants were again the most negative since only 11% believed that goals of the two groups had moved closer together compared to 43% in Hospital B.

Table 8.9: Results of Question 7

National	**Doctors**		**Managers**		**Total Sample**		Doctor-Manager Difference in % Points
1 Moved closer together	331	*50%*	583	*69%*	914	*61%*	*-19%*
2 Not changed	136	*21%*	155	*18%*	291	*19%*	*3%*
3 Moved further apart	188	*29%*	114	*13%*	302	*20%*	*15%*
Count	655	*100%*	852	*100%*	1507	*100%*	
Mean Rating	1.78		1.45		1.59		

Hospital A	**Doctors**		**Managers**		**Total Sample**		Doctor-Manager Difference in % Points
1 Moved closer together	1	*11%*	9	*69%*	10	*46%*	*-58%*
2 Not changed	1	*11%*	3	*23%*	4	*18%*	*-12%*
3 Moved further apart	7	*78%*	1	*8%*	8	*36%*	*70%*
Count	9	*100%*	13	*100%*	22	*100%*	
Mean Rating	2.67		1.38		1.91		

Hospital B	**Doctors**		**Managers**		**Total Sample**		Doctor-Manager Difference in % Points
1 Moved closer together	6	*43%*	3	*50%*	9	*45%*	*-7%*
2 Not changed	0	*0%*	2	*33%*	2	*10%*	*-33%*
3 Moved further apart	8	*57%*	1	*17%*	9	*45%*	*40%*
Count	14	*100%*	6	*100%*	20	*100%*	
Mean Rating	2.14		1.67		2.00		

8.9 Question 8. Which group, in your view, has the most control over the following aspects of service?

(a) Development of service, (b) Availability of facilities (e.g. beds, theatres), (c) Medical staffing levels, (d) Nurse staffing levels, (e) Freedom to admit in-patients, (f) Decision to treat patient

Table 8.10: Results of Question 8

National	Consultants	Nurses	Managers	Chief Executive	Trust Board	Purchasers	Other	Count
% Across All Categories								
Doctors	36%	4%	20%	11%	8%	18%	3%	100%
Managers	39%	6%	21%	7%	9%	15%	3%	100%
Total	38%	5%	20.5%	8.5%	9%	16%	3%	100%

Hospital A	Consultants	Nurses	Managers	Chief Executive	Trust Board	Purchasers	Other	Count
% Across All Categories								
Doctors	22%	0%	22%	42%	2%	2%	10%	100%
Managers	42%	1%	24%	20%	7%	1%	5%	100%
Total	34%	1%	23%	28%	5%	2%	7%	100%

Hospital B	Consultants	Nurses	Managers	Chief Executive	Trust Board	Purchasers	Other	Count
% Across All Categories								
Doctors	32%	2%	18%	25%	5%	15%	3%	100%
Managers	40%	7%	20%	20%	2%	11%	0%	100%
Total	34%	3%	19%	24%	4%	14%	2%	100%

The balance of power over resources in the national sample (where each area of control is given equal weight) is perceived to lie with consultants, and this view is shared by doctors and managers. Consultants have the major share of control in medical staffing levels, freedom to admit in-patients and the decision to treat patients. Managers on the other hand are perceived to have control over facilities (e.g. beds and theatres) and nurse staffing levels (which comprises a third of the budget) while purchasers are believed to have the main say in development of services. The overall ranking of control, using a crude aggregation of unweighted votes, emerges as (1) consultants, (2) managers and (3) purchasers, and this view is shared by both the consultant and manager groups.

Hospital B's response shares similar features. The highest overall proportion of control is attributed by all groups to consultants, but the Chief Executive himself is regarded as the second most influential, followed by the managers.

Hospital A consultants perceive the Chief Executive as being the dominant agent, with purchasers seen as having very little control. The only category in which consultants believe they have control lies in the decision to treat patients. Doctors believe that managers control admission of patients whereas managers believe that doctors have this power. Managers also believe that doctors have the most control over medical staffing levels whereas the consultants themselves believe that this power resides with the Chief Executive. The CEO is regarded by both groups as having control in development of services whereas both Hospital B and the national sample believe that purchasers control this area. On balance Hospital A consultants believe that the Chief Executive controls the hospital whereas managers believe that consultants have overall power across the areas described.

8.10 Conclusion

The main purpose of the Hospital A/Hospital B comparison is to test the impact of sampling methods in the national survey by examining divergences from the national results, while at the same time providing a case study in which similar market conditions allow literal replication (Yin, 1994).

The litmus test set up at the outset consisted of questions 5a and 6a which yielded a strong mood of pessimism among Hospital A consultants that was not reflected in the national sample. If Hospital B were to perform more like Hospital A than the national sample then this would provide evidence to support the view that selection methods in the national survey had biased the sample towards management-friendly consultants through its selection process and through the smaller target of 10 rather than 20 consultants. In the event, the questionnaire survey in Hospital B produced results which were consistent with the national pattern of responses and were at odds with Hospital A. This suggested that Hospital A's results were a product of the local hospital profile rather than of sampling methods. It meant that the national results could legitimately be interpreted as a generalisation of consultant opinion, rather than the view of a sub-section of consultants. The results allowed the conclusion to be drawn that the Trust samples in the national survey were neither too small nor too selective on the part of Chief Executives to allow general conclusions to be drawn about the population of consultants in the country.

CHAPTER 9. QUESTIONNAIRE SURVEY: OPEN QUESTIONS

This chapter draws together the findings of the open questions completed as part of the national survey. The open questions were included in the first place to enhance the overall design of the questionnaire. Their purpose was to add stimulation to the completion process and to counteract boredom and fatigue which could set in partway through the questionnaire. They were inserted in the second half of the questionnaire after a series of closed questions as an opportunity for creative thinking. The last question gave extra space for comments to enable respondents to round off the process and provide a feeling of completion.

A coding structure was devised for each question on the basis of a review of transcripts taken from one third of the sample. The coding structure which emerged was then applied to the full sample of respondents.

9.1 Question 5b. Why has the relationship changed between consultants and managers?

85% of responses to this question was encapsulated within five broad categories: (i) priorities/objectives, (ii) clinicians in management, (iii) communication & information, (iv) leadership and (v) consultants' feelings and power. A further four categories were identified, all of which are dealt with in some detail below.

The responses were coded according to the primary reason where two or more factors were built into the same comment. The first three groupings, i.e. (i) priorities/objectives, (ii) clinicians in management and (iii) communications, inevitably have strong areas of overlap since the line of causation tends to be described as greater involvement by clinicians in management which leads to better communication and which then stimulates appreciation of each other's point of view and a convergence of goals or objectives. Two thirds of responses covered this area (875/1313, 67%), 80% of whom (704/875) associated it with an improvement in relationships between doctors and managers.

Altogether 66% (865/1313) of respondents gave positive accounts of changed relations with only 22% (283/1313) of explanations describing deteriorating relationships. Reference to Question 5a in Chapter 7 (Table 7.17) indicates that 1,504 people attached a rating to the change in relationship between consultant and manager. 17% (109/653) doctors and 10% (82/851) managers declined to answer the open Question 5b to explain 'why' relationships had changed. 95% (283/297) of people who thought that relationships had deteriorated (Q5a) provided an explanation (Q5b). Only 56% (165/293) of those who thought there had been 'no change' proffered an explanation. Likewise 95% (865/914) of those who observed an improvement in relations gave explanations. There is no bias, therefore, in the tendency to supply answers to Q5b between those who take a positive view and those who take a negative view of change.

Figure 9.1: Responses to Question 5b

Open Question Coded Responses to Question 5b - Why have relationships changed between consultants and managers?

The same category of response may apply to positive change and negative change

10 Communication	20 Resources	30 Clinicians in Management	40 Priorities/ Objectives	50 Leadership	60 Consultants' Feelings	70 Consultant Power	80-89 Trend	90 Other	100 Trust Status	110-130 Market Structure
Communication Information	Funding	Directorate structure	Individual patient vs. overall financial aim	Calibre of managers	Frustration	Loss of authority in relation to managers	**80** Initially better, now deteriorating		Freedom	**110** Relationship with other Trusts
	Resources	Clinicians in management	Shared objectives/ Not shared objectives	Leadership	Threatened	Constrained	**81** Initially worse, now better		Local control	**120** Internal market/ Forces external to Trust
	Investment		Working together	Attitude of managers, e.g. receptive	Mistrust	Ignored	**83** Varied		Corporate environment	**130** Nothing to do with Trust status
	Control		Financial footing/ finance driven - leading to pressures & so conflict	Managers transient	Demoralisation	Losing Control	**84** Always good		Decisions nearer to home	
			Understanding		Fearful of change	Losing Power Base			Concentrated on fewer sites	
			Team working		Resentment	Marginalised				
			Partnership		Reluctance to accept	Questioned				
			Climate: one of working together & pragmatism		Realisation/ Acceptance	No support from managers				
			Co-operation & collaboration		Respect towards managers	Conflict over treatment/ admission of patients				
			Them & Us			Cede control to managers (positive)				
			United against purchasers							

Figure 9.1 lists the detailed categories within each heading and gives examples of some of the vocabulary used, e.g. 'frustration' and 'demoralisation' to describe consultants' feelings. The table below summarises the frequency of responses across the headings described here and links them to the response to 5a which showed whether manager-consultant relationships have improved or deteriorated.

Table 9.1: Responses to Question 5b

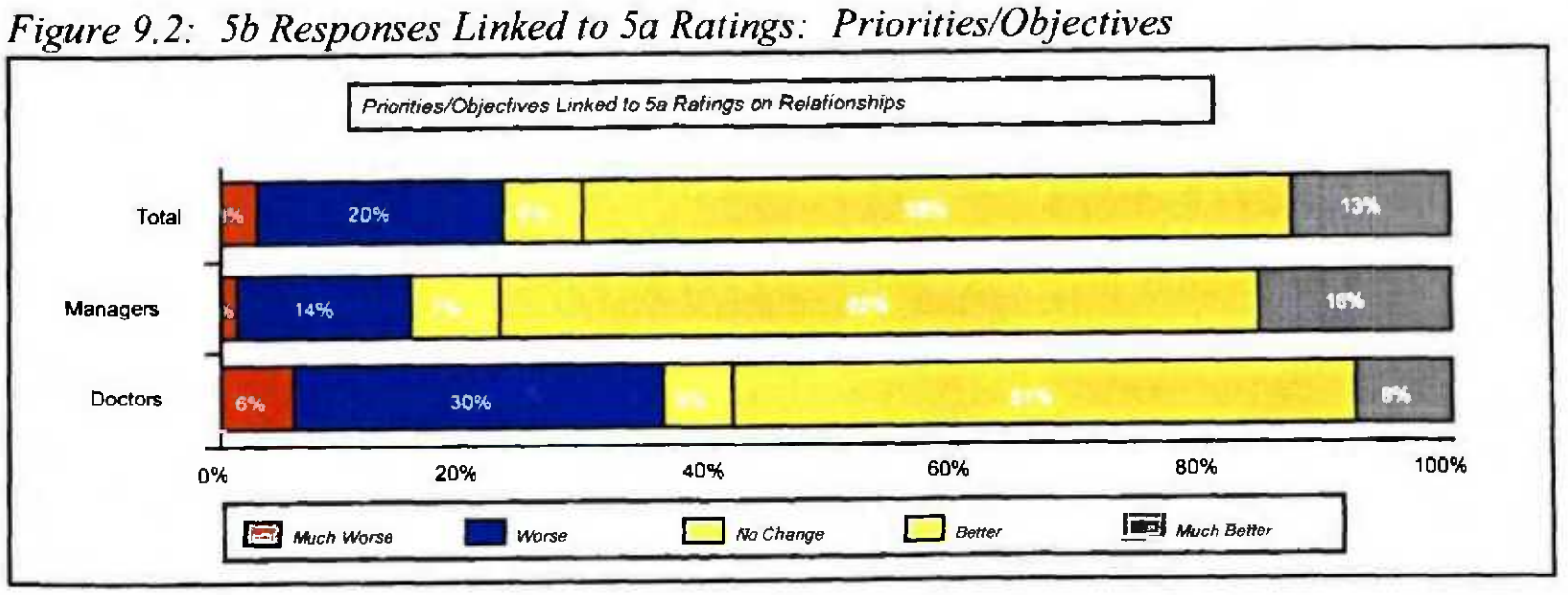
5b	*Doctors*	*Managers*	*Total*	*%*	*Improvement*	*Deterioration*	*No Change*
Priorities/Objectives	164	294	458	*35%*	324	105	29
Clinicians in Management	64	194	258	*20%*	243	9	6
Communication	83	76	159	*12%*	137	16	6
Leadership	75	33	108	*8%*	78	24	6
Trend	56	43	99	*8%*	20	9	70
Consultants' Feelings	20	42	62	*5%*	22	28	12
Consultant Power	35	26	61	*5%*	8	48	5
Resources	22	22	44	*3%*	5	35	4
Other	8	17	25	*2%*	7	5	13
Market Structure	11	11	22	*2%*	5	3	14
Trust status	6	11	17	*1%*	16	1	0
Grand Total	544	769	1313	*100%*	865	283	165
Question 5a Sample	653	851	1504		914	297	293
5b response as % of 5a	83%	90%	87%		95%	95%	56%

9.1.1 Priorities/Objectives

Table 9.2: 5b Responses Linked to 5a Ratings: Priorities/Objectives

5a Ratings :	*Much Worse*	*Worse*	*No Change*	*Better*	*Much Better*	*Total*
Doctors	10	49	9	83	13	164
Managers	4	42	20	181	47	294
Total Priorities/Objectives	14	91	29	264	60	458

Figure 9.2: 5b Responses Linked to 5a Ratings: Priorities/Objectives



35% (458/1313) of respondents described the changes in terms of the goals or objectives of consultants and managers. On the positive side this was described as a 'sharing of objectives', 'working together', 'pragmatism', 'co-operation and collaboration' between the groups and accounted for 37% (324/865) of responses of all those who thought that relationships had improved. Within the managers' group only 16% (46/294) of respondents believed that issues of priorities and objectives were linked to a deterioration in doctor/manager relationships whereas 36% of consultants (59/164) believed this to be the case. However, the majority of both groups thought that relationships had improved due to better co-operation and collaboration. Examples of the comments below highlight whether the respondent was a consultant or manager (showing in brackets the questionnaire response number for audit purposes) and links it to the nature of the response to the previous question 5a:

Consultant - (3091) (Response 5a: Better) On most issues there has been an improvement as Consultants' desires to expand services have fitted in with Trust desires to become 'leading edge'.

Consultant - (1253) (Response 5a: Better) Both understand the financial footing.

Consultant - (1522) (Response 5a: Better) In some respects managers are prepared to listen to consultants (some) more, although the bottom line is almost always financial.

Manager - (1536) (Response 5a: Better) Contracting and business development has led to closer working and understanding of clinical needs in relation to corporate constraints.

Consultant - (2524) (Response 5a: Better) There has been an increase in awareness of managerial problems by consultants.

Manager (1960) (Response 5a: Better) Managers have focused on helping consultants to achieve their objectives as a method of motivating consultants to manage resources more effectively.

Manager (CEO) (1441) (Response 5a: Better) Better understanding of each other's roles and grown in respect.

To some extent this convergence of objectives has been a by-product of poor external relations with the purchaser and a means of dealing with adversity created by the internal market:

Consultant (1677) (Response 5a: Better) The only way to cope with the immense pressure caused by the internal market system is by co-operation. Also, in the

new system consultants feel less secure and are forced therefore to be more co-operative.

Manager (2181) (Response 5a: Better) Fostered a climate of 'working together'; still a long way to go; the HAs have become the focus for being responsible for lack of resources etc.

Consultant (4163) (Response 5a: Better) United against a common foe! - the Purchasers who are seen as incompetent.

Consultant (2005) (Response 5a: Better) Common aim of survival.

The negative side of objectives/priorities, however, was given by people who felt that relationships had deteriorated. 37% (105/283) of this group believed that there was a conflict of interests between the needs of the individual patient and the overall financial aim of the Trust, that objectives were not shared and that the financial footing adopted by the Trust had led to pressures and conflict. Examples of verbatim comments include:

Consultant (1254) (Response 5a: Much Worse) Conflict of interest. Trust financially oriented at all costs. Consultants patient oriented at all costs.

Manager (1494) (Response 5a: Worse) The need for financial control fundamentally clashes with the increasing amount of clinical need - neither side believes that the other understands their pressures.

Consultant (2813) (Response 5a: Much Worse) They work to different agendas with 'lip service' paid to common ground.

Consultant (1527) (Response 5a: Worse) Pressure of clinical work means contact is minimal; aims and objectives are not clearly shared by these two groups.

Consultant - (2175) (Response 5a: Worse) Loss of common objective - to provide quality of care.

Consultant - (5474) (Response 5a : Worse) Many of the senior managers have found a conflict between their professional (e.g. nursing) views and Trust Priorities - the vision of a National Health Service has been replaced by a small business mentality.

Manager - (2846) (Response to 5a: Worse) There is still an uneven balance; some clinicians are signed up to business but others are clinically led only.

Only 6% of individuals commenting in this category associated priorities/objectives with 'no change' in the relationship between consultants and managers in question 5a. The majority (71%) believed that priorities/objectives were associated with an improvement in relationships. A tone of 'it was ever thus' emerges from respondents who believed that relationships had not changed:

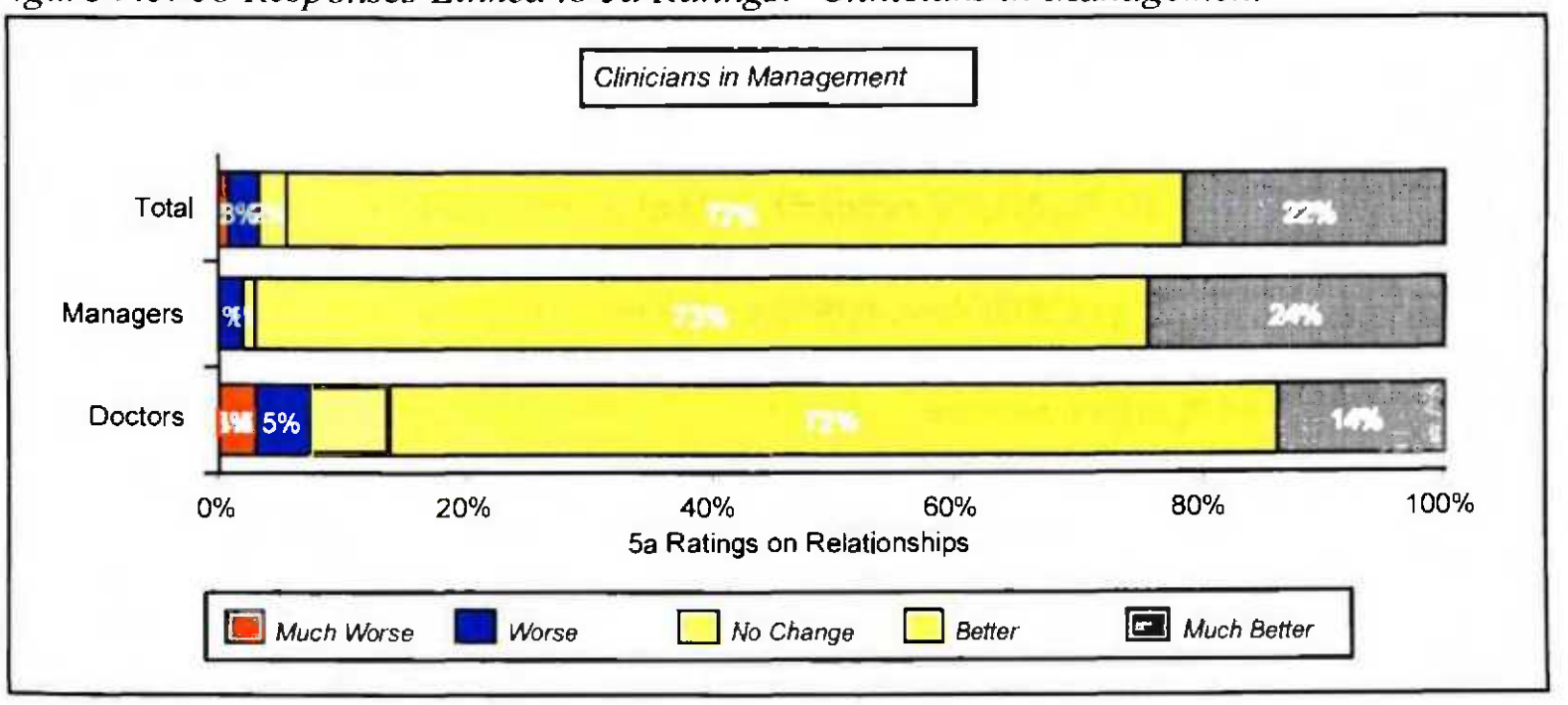
> *Consultant - (3099) (Response 5a : No Change) The managers generally seem to have very little understanding of the ethos of the hospital and patient care. They only seem to wish to balance the books.*
>
> *Manager (2265) (Response 5a : No Change) There is still a culture of 'them and us' irrespective of which stance you are taking - even when some clinicians are also managers.*
>
> *Consultant - (2143) (Response 5a : No Change) Some consultants still feel distant to the aims etc of the Trust.*

9.1.2 Clinicians in Management

Table 9.3: 5b Responses Linked to 5a Ratings: Clinicians in Management

5a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	2	3	4	46	9	64
Managers		4	2	141	47	194
Total Clinicians in Management	2	7	6	187	56	258

Figure 9.3: 5b Responses Linked to 5a Ratings: Clinicians in Management



Involvement of clinicians in management has provided the vehicle for much of the movement towards common aims and objectives and 20% (258/1313) of all respondents described this factor as the reason for relationship changes. Unlike the preceding factor (priorities/ objectives) which accounted for more than a third of positive and negative change alike, the issue of clinicians in management was highlighted mainly by those who felt that changes had

been constructive. 28% (243/865) of individuals who observed improved relationships referred to directorate structure and management involvement of clinicians as positive reasons while only 3% (9/283) of those who observed deterioration gave this as their primary reason. Some consultants saw a division and growing tension between those involved in the management process and those who are not. 94% of respondents on this group (243/258) felt that changes had improved relationships and 75% of the group (194/258) were managers, compared to an overall representation of 59% (769/1313) in the sample.

The idea of two consultant camps, representing those engaged in management and those not, was articulated by consultants:

> *Consultant (2146) (Response to 5a: No Change) Consultants not in management continue to be suspicious and fear control from outside; those involved in management are so because they did not previously suffer from these delusions.*

> *Consultant (1104) (Response to 5a: No Change) Relationships here have always been quite good but there is tension developing between clinical directors and their consultant colleagues.*

> *Consultant (3229) (Response to 5a: Better) In my case better thru' my work as clinical director. For many consultants not involved in management, worse.*

The overlap between priorities/objectives in the earlier classification and the use of management structures to effect this was made explicit in responses such as:

> *Service/Business Manager (3234) (Response to 5a: Much Better) Clinical directorate structure and development of this has resulted in greater understanding of each others' objectives/concerns + much more joint working, e.g. on service developments, business plans etc.*

> *Consultant - Board Director (1182) (Response to 5a: Better) More involvement of clinicians in management. Decisions more explicit; but then that means <u>some</u> consultants don't like it.*

The preponderance of managers, i.e. (188/258) managers compared to (55/258) doctors, reflecting that clinicians in management is 'a good thing' is highlighted, e.g.

> *Manager (1361) (Response to 5a: Much Better) Consultants have been brought into management, pricing, contracting, quality, patient issues.*

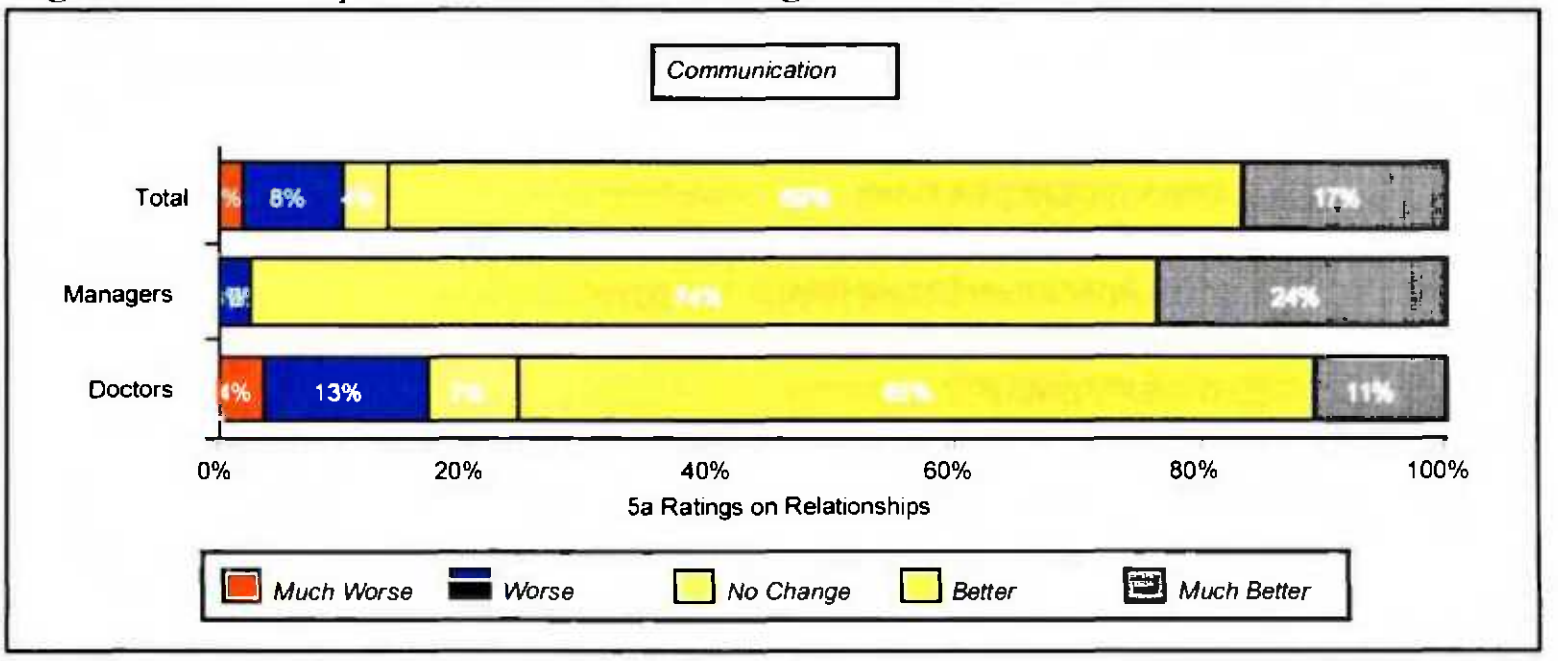
> *Manager (CEO) (2860) (Response to 5a: Much Better) With the involvement of clinical directors at the heart of the decision making process; consultants have felt that they can influence what happens.*

9.1.3 Communication

Table 9.4: 5b Responses Linked to 5a Ratings: Communication

5a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	3	11	6	54	9	83
Managers		2		56	18	76
Total Communication	3	13	6	110	27	159

Figure 9.4: 5b Responses Linked to 5a Ratings: Communication



Communication leads on from the issue of clinical involvement in management and the creation of directorate structures. 12% of respondents overall (159/1313) highlighted communication and information as the reason for changed relationships, 86% of whom (137/159) attributed it to improvements while 10% (16/159) of these people considered that communication had deteriorated.

More doctors responded in terms of communication than did managers, representing 52% (83/159) of the group. While the overall impression was one of improvement, the tone of managers was decidedly more positive since 97% (74/76) felt that communication had improved with 24% (18/76) saying that relationships were *much better*. 76% (63/83) of doctors felt that communication had improved; 11% (9/83) believed it was *much better* with 17% (14/83) claiming it had deteriorated.

The overlap between communication and clinicians in management was apparent in the logic of some responses which stressed day to day contact and working towards the same goals:

> *Consultant (1799) (Response to 5a : Much Better) More communication between groups. Generally working towards same goals. More understanding of each other's problems and united against central bureaucracy.*

> *Consultant (2140) (Response to 5a : Better) Some more discussion; an attempt to make smaller directorates and therefore allow better (i.e. fuller) representation of specialties.*

Consultant (1995) (Response to 5a: Better) Manager/clinician divide has diminished through personal contact and escalating number of meetings to decide policy.

Manager (2134) (Response to 5a: Much Better) Communication improved; consultants are more involved in decision making and better able to make choices because they are better managed.

Consultant (2855) (Response to 5a: Better) More day to day contact with managers of directorates; hence improved understanding of differing roles/stresses; more senior managers not obviously aware of local issues.

Consultant (2523) (Response to 5a: Better) Common aims <u>when</u> communication is good.

Diverging views within the same Trust show how managers' positive views may be at odds with the clinical perspective:

Manager (1031) (Response to 5a: Better) Increased communication - working together in partnership.

Consultant (1035) (Same Trust as 1031) (Response to 5a: No Change) Communication poor. Money always available for 'prestige projects'. Money not available for clinical services.

Some consultants took a grim satisfaction in managers' new obligation to talk to them since Trust status:

Consultant (2232) (Response to 5a: Better) They now do have to communicate on a regular basis.

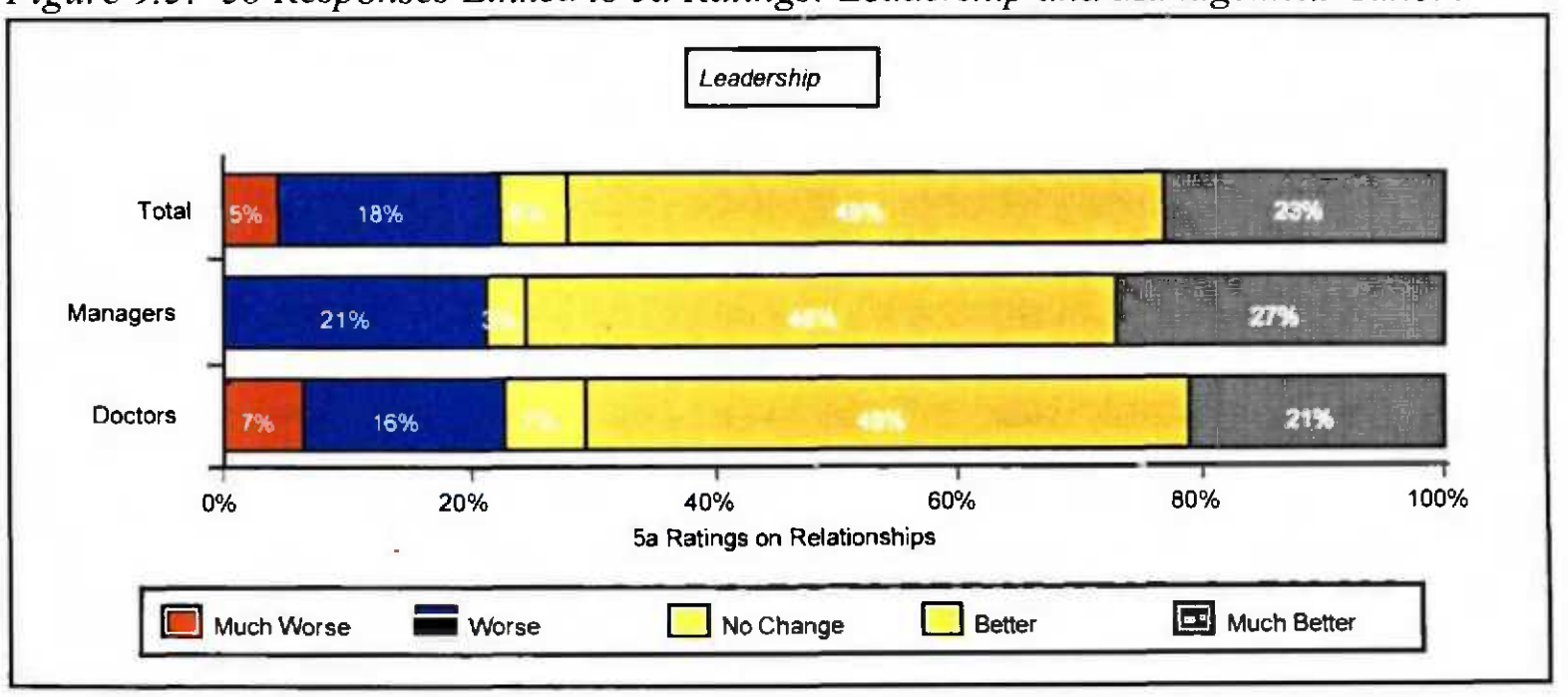
Consultant (2274) (Response to 5a: Better) Because they <u>have</u> to talk now.

9.1.4 Leadership and Management Calibre

Table 9.5: 5b Responses Linked to 5a Ratings: Leadership and Management Calibre

5a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	5	12	5	37	16	75
Managers		7	1	16	9	33
Total Leadership	5	19	6	53	25	108

Figure 9.5: 5b Responses Linked to 5a Ratings: Leadership and Management Calibre



Leadership and management calibre was highlighted by 8% of respondents (108/1313) as the reason for change. This pattern was reflected across the positive and negative divide with 9% of *improvement* and 8% of *deterioration* votes being explained by this factor. Over two thirds of these respondents were consultants.

Leadership quality was selected by 14% of doctors in the sample (75/544) compared to only 4% of managers (33/769). The comments were generally positive with 76% (25/33) of managers and 71% of doctors (53/75) suggesting an improvement in relationships. The calibre of the CEO was noted in both positive and negative contexts and, unlike the previous three categories, the issue of leadership and management quality was capable of being separated from Trust status:

> *Consultant (1424) (Response to 5a: Much Better) Excellent CE who knows how to deal with consultants, patients, staff and builds up a good team. Good chairman and less local political interference (from councillors).*

> *Consultant (2590) (Response to 5a: No Change) Almost uniquely good relationship in the hospital before and after trust status; excellent CE/DGM inspires confidence and loyalty in consultants and managers through being obviously interested in services for patients rather than self seeking.*

Consultant (2629) (Response to 5a: Better) Excellent CE who listens responsively to medical staff and vice versa; good team work.

Manager (2029) (Response to 5a: Worse) I don't think this worsening is due to Trust status, more a lax management style has resulted in minor problems becoming much more severe. This hopefully will change with a new Chief Exec.

The notion of 'one man's meat is another's poison' is again apparent in the critical tone of a consultant and the optimistic tone of a manager within the same Trust:

Consultant (2181a) (Response to 5a: Worse) Numerous changes in management.

Manager (2181b) - Same trust as above - (Response to 5a: Much better) During the last six months change of CE and radical change of culture and working arrangements.

Consultants may spend over thirty years in the same hospital, starting from their appointment in their thirties and ending at retirement. One of the important dynamics between consultants and managers within hospitals is due to the transience of managers who are pursuing their career and the stability of the consultant population who have reached the top of their career ladder. It would seem that implementation of Trust status has had the desired effect of improving the quality of management through changes in the management structure and in making Trusts more attractive to career managers:

Consultant (1817) (Response to 5a: Worse) Managers tend to be transient but doctors feel a commitment to the service and are left with the consequences of cost saving procedures which can affect services.

Consultant (1318) (Response to 5a: Better) Management have certainly remained in post longer.

Consultant (2003) (Response to 5a: Much Better) The new managers on the whole are more attuned with the consultants body - less confrontational attitudes.

Manager (2170) (Response to 5a: Better) Consultants have experienced the benefits of effective management within an organisation which previously had little or no business focused culture.

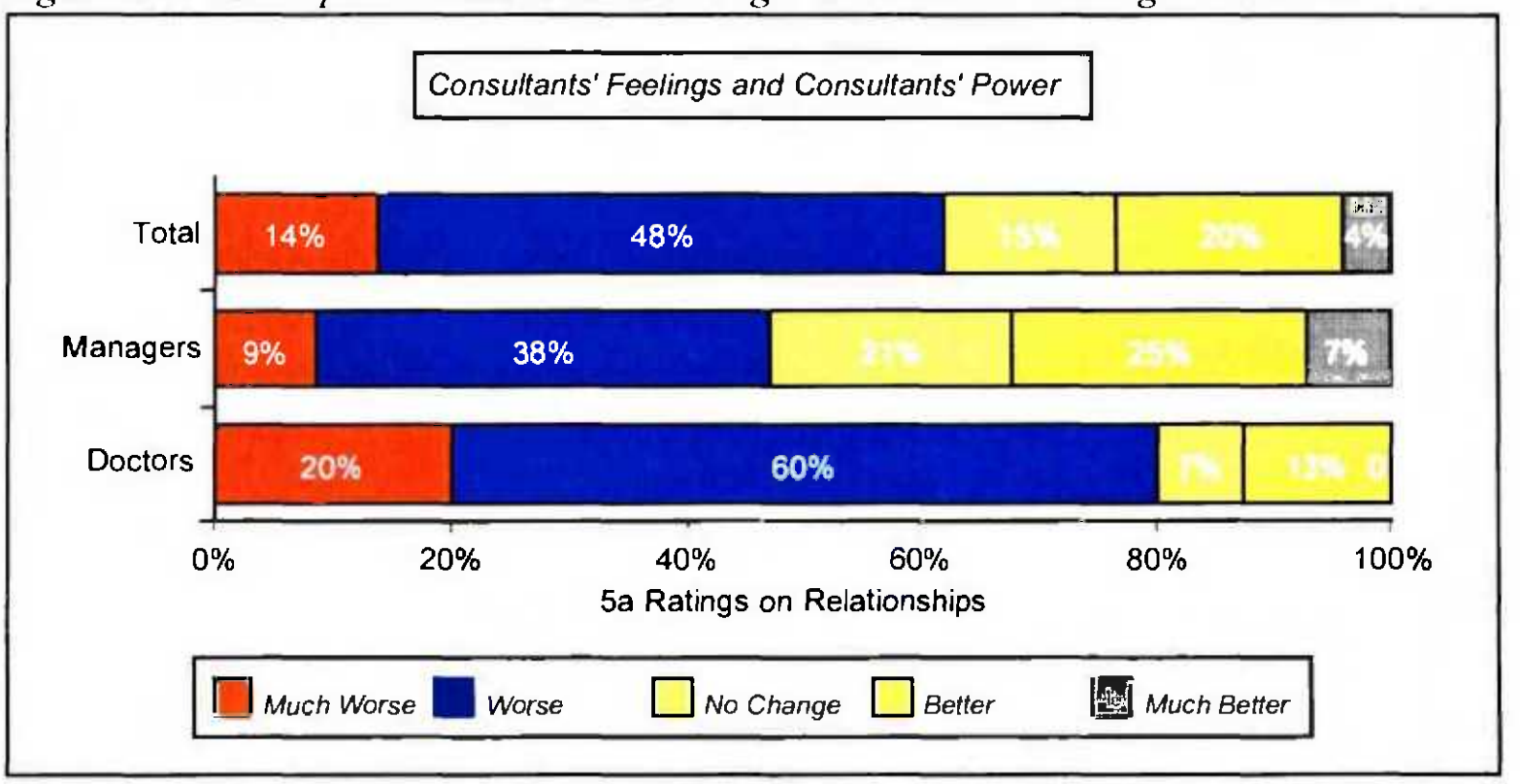
Consultant (2895) (Response to 5a : Better) Higher quality managers with a more developed management structure.

9.1.5 Consultants' Feelings and Consultant Power

Table 9.6: 5b Responses Linked to 5a Ratings: Consultants' Feelings and Power

5a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	11	33	4	7		55
Managers	6	26	14	17	5	68
Total Cons. Feelings /Power	17	59	18	24	5	123

Figure 9.6: 5b Responses Linked to 5a Ratings: Consultants' Feelings and Power



10% of all respondents described consultants' feelings and power status as the reason for changes in the relationship between consultants and managers. Only 4% (30/865) of those who saw an improvement in relationships used these factors to describe the change whereas 27% (78/283) of those who saw a deterioration used this reason. Descriptions of consultants' feelings include the words *frustration, threatened, mistrust, demoralisation, fearful of change, reluctance to accept* or, on the positive side, *realisation/acceptance* and *respect towards managers*. Consultant power is described in terms like *loss of authority in relation to managers, constrained, ignored, losing control, losing power base, marginalised, questioned, no support from managers, conflict over treatment or admission of patients* and *ceding control to managers*.

The response in this category was reasonably balanced with 45% (55/123) comprising doctors and 55% (68/123) managers. 80% of doctors (44/55) believed that loss of authority had diminished the relationship between the groups. A smaller, but still substantial, group of managers who responded in this category (32/68, 47%) observed an adverse impact on relationships through consultants' loss of power and esteem. 10% (55/544) of doctors compared to 6% (66/769) of managers responded to question 5b in these terms. In short, consultant views of loss of morale and authority dominated these responses.

Consultants' Feelings

Managers referred to consultants' conservatism to explain their dislike of recent developments:

> *Manager (1416) (Response to 5a: Better) Some consultants feel threatened by continual change, some welcome it openly.*
>
> *Manager (1418) (Response to 5a: Worse) Mistrust - consultants not wanting to change practice even though the organisation needs to. Creates pressures.*
>
> *Manager (1443) (Response to 5a: No Change) The consultant body on the whole is conservative and reluctant to change.*

The market and Trust changes generated a degree of mistrust which was made explicit:

> *Consultant (1818) (Response to 5a: Worse) General mistrust of 'market forces' motivation.*
>
> *Manager (2031) (Response to 5a: Worse) Consultant colleagues appear suspicious of board/executive motives and are irritated by constant financial pressures.*

Some managers felt a degree of contempt emanating from consultants which had not changed with Trust status:

> *Manager (2386) (Response to 5a: No Change) Although there are different issues, overall there is mistrust and even loathing for managers; managers need to adopt an 'ethical value system' to be taken seriously, otherwise they will always be seen as 'administrators' or civil servants!*
>
> *Manager (5918) (Response to 5a: No Change) They treat us like dirt now, and they did before we went Trust.*

Consultants' Power

A deep sense of injury emerged from some consultants and a feeling of being treated badly or being sidelined through lack of recognition:

> *Consultant (2397) (Response to 5a: Worse) Failure to accept consultants' opinion if it counteracts current 'management' ideas which have no proven base of effectiveness; in general if anyone is wrong it is the doctor.*

Consultant (3098) (Response to 5a: Worse) Exclusion/marginalisation of consultant body - many measures taken to achieve ranging from imposition of medical staff at senior levels to withdrawal of consultants' dining room.

Consultant (1456) (Response to 5a: Worse) The feeling that consultants are simply employees of the Trust rather than the Trust being the mechanism by which the consultants can exercise their art.

The opposite perspective, taken by managers, saw the consultant power base as remaining intact:

Manager (1468) (Response to 5a: No Change) Always worked together; consultants always ensure they get their way.

Manager (2126) (Response to 5a: No Change) Consultants still treated like gods and get whatever they want while everybody else has to struggle.

A stronger view, however, conveyed a feeling of constraint and encroachment on clinical ground in which the balance of power had shifted away from consultants:

Consultant (2240) (Response to 5a: Much Worse) Conflict between consultants and managers over admission/treatment of patients.

Manager (1497) (Response to 5a: Worse) Consultants appear to think that managers are taking away from their power base and are interfering in clinical matters.

Manager (1609) (Response to 5a: Worse) They don't like their clinical judgement being questioned.

The loss of consultant power, even where it produced worse consultant-manager relationships, was not considered to be a bad thing in all cases, showing a degree of dispassion if not approval:

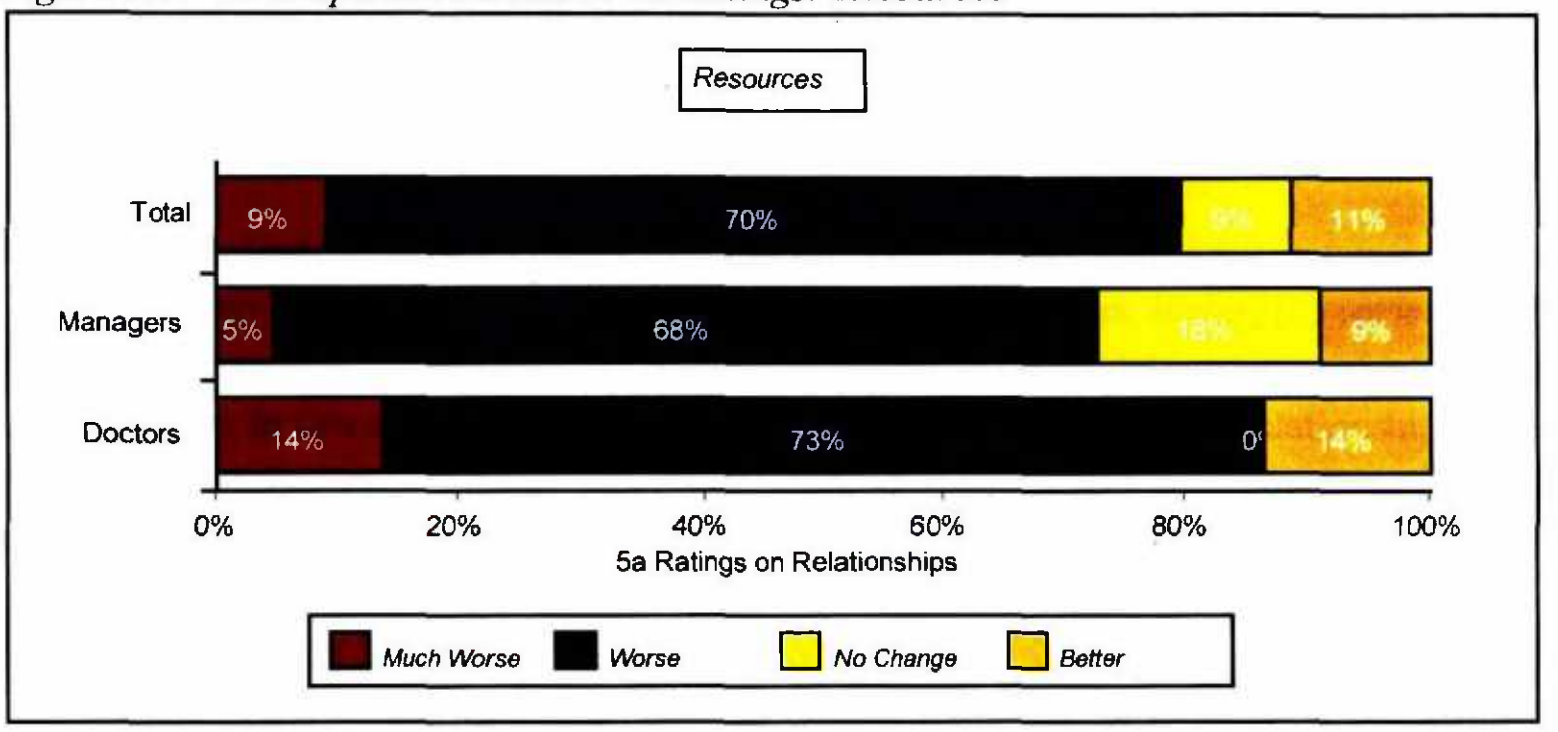
Consultant (1715) (Response to 5a: Worse) The strong sudden shift to financial emphasis and the increasing influence and power of managers (not necessarily a bad thing).

9.1.6 Resources

Table 9.7: 5b Responses Linked to 5a Ratings: Resources

5a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	3	16		3		22
Managers	1	15	4	2		22
Total Resources	4	31	4	5	0	44

Figure 9.7: 5b Responses Linked to 5a Ratings: Resources



Only 3% of respondents (44/1313) identified resources as the reason for changes in consultant/manager relationships, but among those who felt that relationships had deteriorated it accounted for 12% of the response (35/283). Issues of funding, resources, investment and control were identified as the source of conflict between doctors and managers. This follows on the heels of consultant power where financial priorities may undermine professional autonomy to practice and, likewise, it overlaps with the issue of priorities/objectives where service and financial aims may conflict.

A sense of pessimism and disappointment with the internal market was conveyed:

> *Consultant (1368) (Response to 5a: Much Worse) Despite very hard work we were going further into debt resulting in dissatisfaction and frustration.*

> *Manager (2025) (Response to 5a: Worse) Consultants see managers as having failed to obtain better resource profile from internal market.*

The tension between resource management and quality was highlighted by some:

> *Consultant (1675) (Response to 5a: Worse) Financial pressure on managers has become so great that they are forced into imposing saving measures without adequate consultation or regard for quality.*

Consultant (4429) (Response to 5a: Worse) The increasing cash crisis has reduced the ability to offer a quality service and the pressure on acute units to downgrade (merge) has dented morale severely.

The position of service managers as bending to the demands of senior management became apparent:

Manager (2532) (Response to 5a: No Change) There is more pressure to cut budgets and still provide a quality service; constantly under pressure from the Trust and higher management.

9.1.7 Changes Over Time and Variation

8% of respondents described changes in consultant/manager relationships in terms of trends, i.e. (a) *initially better, now deteriorating*; (b) *initially worse, now better*; (c) *varied*, and (d) *always good* (without qualifying remarks about why). The modal response of both doctors and managers in this category represented, on balance, no change in the relationship between doctors and managers. This feature would have links with other factors such as leadership calibre; financial pressures have a particular bearing on the varying fortunes:

Manager (1533) (Response to 5a: No Change) There have been areas of improvement and areas or decline. There are obvious areas of financial pressure and of control in activity which affect the relationship.

Consultant (2007) (Response to 5a: No Change) For some it is better for others worse or no change - always some consultants not prepared to listen - less managers in this category. Trust has financial difficulties so there is a cutback in staff and surgery in particular.

Manager (2018) (Response to 5a: No Change) The changes from 'much worse' to 'much better' depend on the agenda; until the financial crisis I would have said 'much better'; this is I think understandable.

9.1.8 Trust Status

Just over 1% of respondents (17/1313) used issues related to Trust status to explain changes in manager/consultant relationships and these were almost all (16/17) associated with positive change. *Freedom, local control, corporate environment, decisions nearer to home* and *concentration on fewer sites* were among the descriptions which were grouped under this heading.

9.1.9 Market Structure

Nearly 2% of respondents (22/1313) identified features of market structure as explanatory factors, most of whom (12/22) had identified *no change* in the relationship with the remaining 10 spread across the positive and negative view of change. Three sub-sets were identified under market structure: *relationship with other Trusts; internal market forces/forces external to Trust; nothing to do with Trust status.*

9.2 Question 6b. Why have services to patients changed ?

1,314 responded to this open question, compared 1505 for the closed Question 6a. This was similar to the 5a/5b response relationship outlined earlier which amounted to 1313/1504. 87% (1314/1505) of people who responded to Question 6a gave an explanation of 'why' services to patients had changed. The majority of people who declined to give a reason were among those who felt that there had been no change in the service, since 30% (72/243) of the group did not comment compared to 7% of those who saw a deterioration and 10% of those who felt services had improved.

Answers have been structured under seven headings, which are reported in descending order of magnitude. The frequency of responses is summarised in the table which follows. Detailed sub-categories are identified in Figure 9.8 which shows frequencies and gives examples of quotes within the sub-categories.

Table 9.8: Response to Question 6b

6b	*Doctors*	*Managers*	*Total*	*%*	*Improvement*	*Deterioration*	*No Change*
Customer Care	109	259	368	*28%*	345	5	18
Changes since trust status	112	192	304	*23%*	260	36	8
Resources	132	106	238	*18%*	93	125	20
Quality Factors	91	92	183	*14%*	156	20	7
Qualified Improvement	65	58	123	*9%*	18	24	81
Workload	27	32	59	*4%*	19	36	4
No Impact	13	22	35	*3%*	2		33
Other	3	1	4	*0%*	4		0
Grand Total	552	762	1314	*100%*	897	246	171
Question 6a sample	651	854	1505		997	265	243
6b response as % of 6a	85%	89%	87%		90%	93%	70%

Each of the headings and sub-headings has been coded as a means of organising the views of respondents (detailed in Figure 9.8) although there is clearly some overlap between groupings. The factors and their sub-components are treated in greater detail in the following sections.

Figure 9.8: Responses to Question 6b - Frequency of Responses and Sample Quotes

Open Question Coded Responses to Question 6b - Why have services to patients changed?

10 Customer Care Frequency 28%	20 Quality Factors Frequency 14%	30 Resources Frequency 18%	40 Workload Frequency 5%	50 Changes *(since Trust status)* Frequency 23%	60 Qualified Improvement Frequency 9%	70 No Impact Frequency 3%
11 Responsive Frequency 6% *Manager (1671) (Response to 6a: Better) Much more responsive to patients' comments and a change in how timely our responses are. More focused in quality delivery.*	20 Quality Frequency 3% Manager (1667) (Response to 6a: Worse) No emphasis on quality of care given - no time to see projects through no time, no time! Consultant (1670) (Response to 6a: Worse) Quantity and quality of care has remarkably deteriorated.	30 Resources Frequency 10% Consultant (2807) (Response to 6a: Worse) Multifactorial - less resources, more demand, poorer nurses, less commitment of staff to patient care, changing practices of junior hospital doctors. Consultant (1456) (Response to 6a: Worse) Too many demands on an underfunded service. Probably not a Trust issue, rather a central government one.	40 Workload Frequency 1%	51 Service configuration/ development Frequency 3% Consultant (1997) (Response to 6a: Better) Development of specialist services i.e. one stop clinics, specialist appointments etc	61 Better for some, worse for others/ Some things better, others worse, e.g. access better, quality worse/ Patients Charter offset by deteriation elsewhere Frequency 8%	71 Always been good - staff still strive/ work hard/ 'killing' themselves to achieve everything Frequency 6%
12 Patient focused Frequency 6%	21 Care, e.g. staff stressed, rushed Consultant (2387) (Response to 6a: Worse) Too much pressure on those delivering the service to work happily and effectively. Manager (2569) (Response to 6a: Worse) Patients discharged early, they feel their treatment is rushed; also staff are much busier and cannot always give the necessary time.	31 More - through purchaser negotiations	41 Demand on service; workload increase; overheated hospital Frequency 1%	52 Clinicians in management	62 Initially better, then worse	

Figure 9.8: Responses to Question 6b - Frequency of Responses and Sample Quotes

Open Question Coded Responses to Question 6b - Why have services to patients changed?

10 Customer Care	20 Quality Factors	30 Resources	40 Workload	50 Changes *(since Trust status)*	60 Qualified Improvement	70 No Impact
13 Consultant focus on individual patient (better/worse)	22 Infrastructure/ facilities/ environment Frequency 1% Consultant (1428) (Response to 6a: Better) Lots of changes to the fabric of the building and change of attitude of the staff. Waiting times come down. Consultant (1874) (Response to 6a: Better) Environment improved; more services provided locally; more consultants employed; more efficient organisation because people feel empowered and involved.	32 Targeting - good & bad. Bad, e.g. diverted to bureaucracy Frequency 2%	42 Higher volume of service, throughput; service development Frequency 2%	53 Team working/ communication/ cohesion Frequency 2%	63 Superficially better Frequency 1%	

Figure 9.8: Responses to Question 6b - Frequency of Responses and Sample Quotes

Open Question Coded Responses to Question 6b - Why have services to patients changed?

10 Customer Care	20 Quality Factors	30 Resources	40 Workload	50 Changes *(since Trust status)*	60 Qualified Improvement	70 No Impact
14 Customer Orientated Frequency 2%	23 Waiting list/ times/ access Frequency 5% Manager (2763) (Response to 6a: Better) Forced us to consider what we do well or not and to plan around this; waiting times are dramatically improved; services have become more focused. Manager (2882) (Response to 6a: Better) Overall the service has become better but mainly due to reducing waiting times for some groups of patients; however quality of service has not significantly improved and operating two tier quality standards for GPs has created tensions.	33 No increase in relation to workload Frequency 2%	43 Quantity reduced Frequency 1%	54 Effort/ focus/ awareness of managers, doctors & Trust Frequency 7% Consultant (1368) (Response to 6a: Better) Increased effort and better organisation Consultant (1423) (Response to 6a: Better) Better focus of management and doctors		
15 Emphasis on patient/ patient's perspective Frequency 5%	24 Complaints Frequency 1%	34 Allocation of resources	44 Limits imposed on amount of treatment; forced to work to contract	55 Organisation Frequency 1%		

Figure 9.8: Responses to Question 6b - Frequency of Responses and Sample Quotes

Open Question Coded Responses to Question 6b - Why have services to patients changed?

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Figure 9.8: Responses to Question 6b - Frequency of Responses and Sample Quotes

Open Question Coded Responses to Question 6b - Why have services to patients changed?

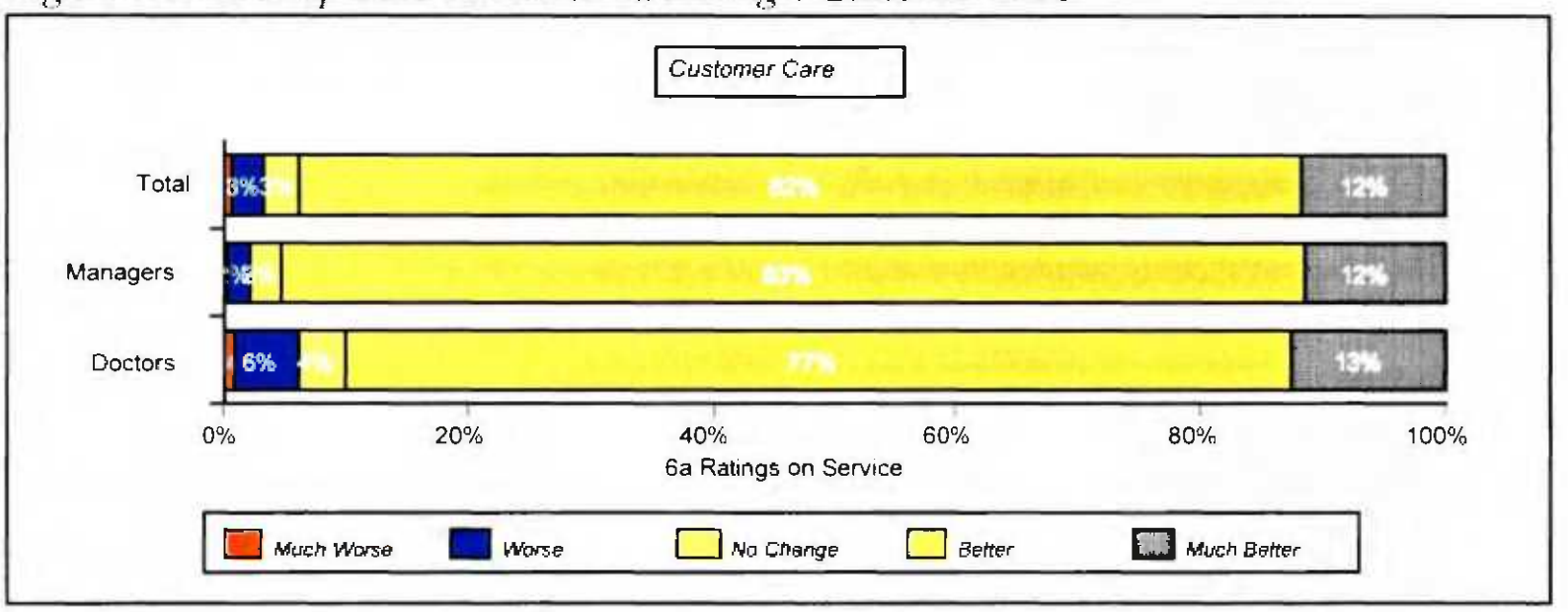
10 Customer Care	20 Quality Factors	30 Resources	40 Workload	50 Changes *(since Trust status)*	60 Qualified Improvement	70 No Impact
19 Patients Charter *(sometimes pejorative)* Frequency 4% *Manager (1031) (Response to 6a: No Change) Reliance on conforming to Patients Charter instead of 'proper' clinical quality issues. Consultant (1799) (Response to 6a: Much Better) Quality of service and implementation of Patients Charter have forced everyone to look at quality from the patient's point of view.*	**27 Choice - less for referrers**			**58 Emphasis/ priorities** Frequency 6% Consultant (1826) (Response to 6a: Worse) Not directly linked to trust status, more to do with the reforms. Too much has been spent on administration/ management by clinical staff - the balance is wrong; also the impact of insufficient resources. Manager (2027) (Response to 6a: Much Worse) Greater financial pressures have led to prioritisation which has not benefited the majority of patients; staff are less valued leading to poor attitude towards patients.		
	28 Training			**57 Too many rules**		

9.2.1 Customer Care

Table 9.9: 6b Responses Linked to 6a Ratings: Customer Care

6a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	1	6	4	84	14	109
Managers	1	5	7	216	30	259
Total Customer Care	**2**	**11**	**11**	**300**	**44**	**368**

Figure 9.9: 6b Responses Linked to 6a Ratings: Customer Care



The expression 'customer care' was introduced with the internal market and some respondents have used it as a means of describing the change in focus towards the users of the service, namely the patient. *Patient focused* was another popular expression which was used as jargon or short-hand to mean a change in perspective away from staff or organisational convenience towards the patient. The umbrella concept of *customer care* accounted for 28% of the primary factors used to explain changes in the service to patients and, among those who believed that services had improved, accounted for 38% of comments (345/897) compared to 5% (13/254) of respondents who thought that services had deteriorated.

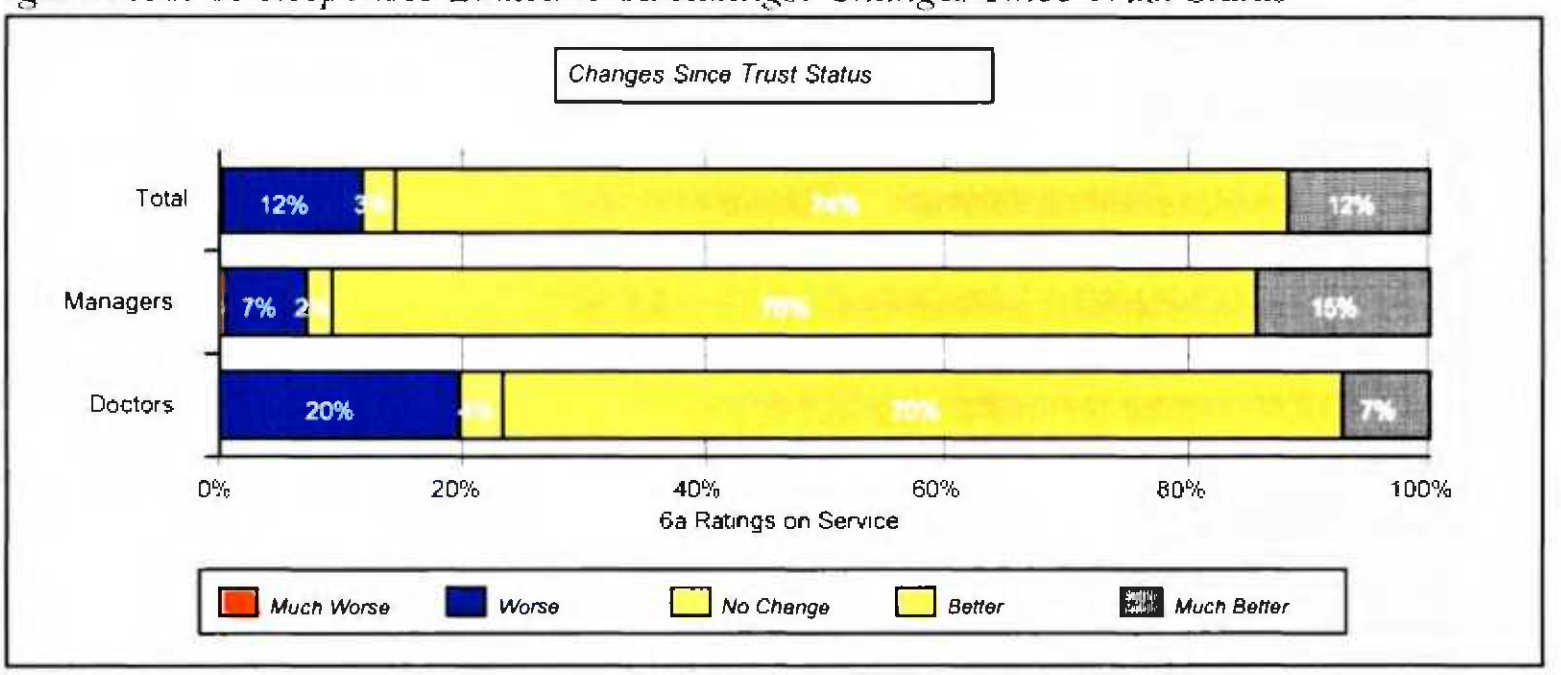
This was the most popular area of comment among managers with 34% (259/762) describing service changes in these terms compared to 20% (109/552) of doctors. Both groups perceive these factors as having a beneficial effect on services to patients, with 95% (247/259) of managers and 90% (98/109) of doctors associating customer care factors with *better* or *much better* services.

9.2.2 Changes Since Trust Status

Table 9.10: 6b Responses Linked to 6a Ratings: Changes Since Trust Status

6a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors		22	4	78	8	112
Managers	1	13	4	146	28	192
Total Changes Since Trust Stat	1	35	8	224	36	304

Figure 9.10: 6b Responses Linked to 6a Ratings: Changes Since Trust Status



Changes since Trust status account for 23% of responses, the two largest sub-groups of which concern the effort and emphasis invested by the Trust organisation to improve patient services. 14% of comments associated with poorer services (36/254) fit into this category compared to 29% (260/897) of comments linked to improved services.

20% of doctors (112/552) and 25% of managers (192/762) gave examples of change related to Trust status as explanations for changes in service. 90% (172/92) of management responses linked this to improvements with 7% (14/192) linked to deterioration, compared to 77% (86/112) of doctors who were positive and 20% (22/112) who saw a negative impact in the changes.

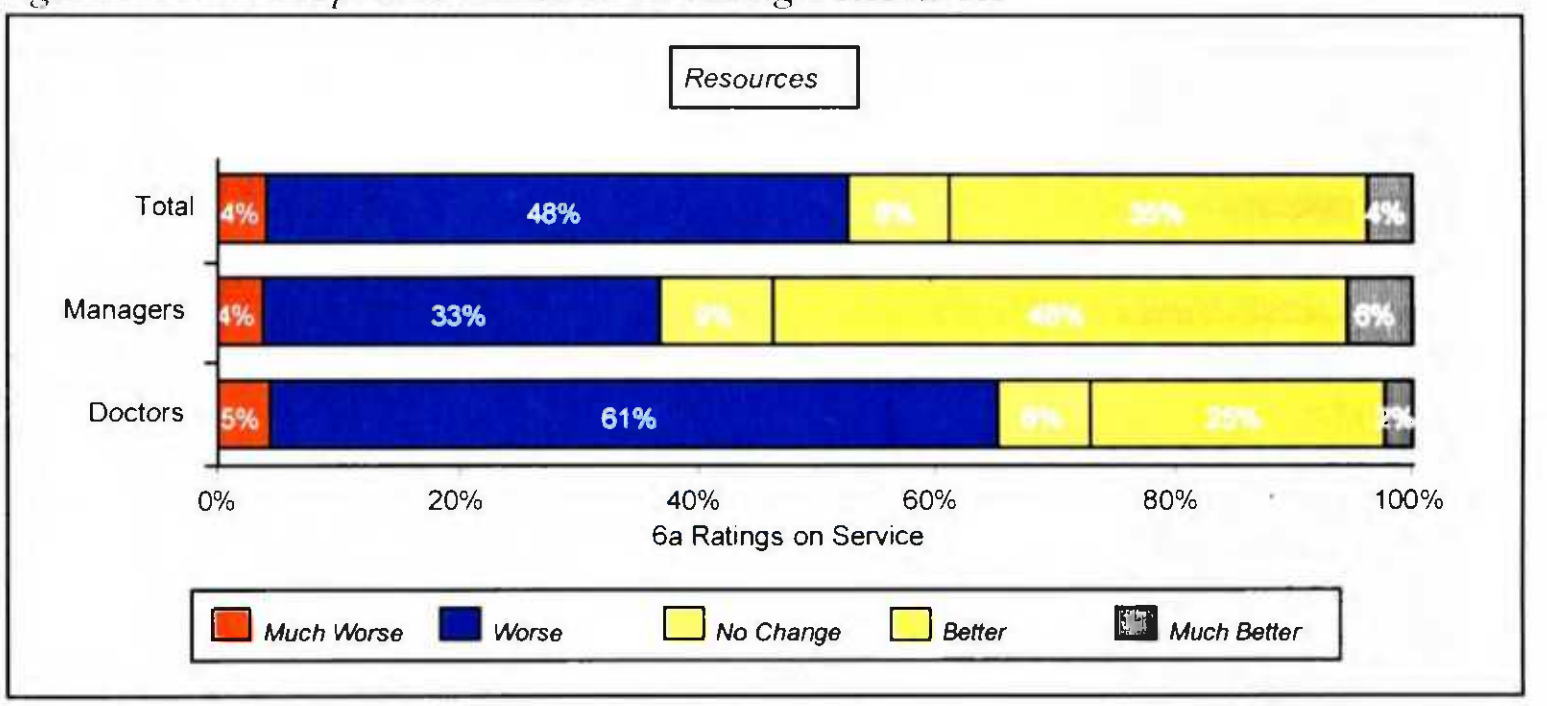
Nearly all negative comments resided in the sub-category of *emphasis/priorities*, with 19/22 of the doctors' and 13/14 of managers' expressions of poor service since Trust status. The emphasis on, for example, throughput or volume of service was considered to be excessive and damaging towards quality.

9.2.3 Resources

Table 9.11: 6b Responses Linked to 6a Ratings: Resources

6a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	6	80	10	33	3	132
Managers	4	35	10	51	6	106
Total Resources	10	115	20	84	9	238

Figure 9.11: 6b Responses Linked to 6a Ratings: Resources



Resources account for some of the issues of priority and balance included above. 18% of comments highlighted resources or workload/funding relationships as the immediate cause of change to patient services. 10% of respondents (93/897) who believed that services had improved used resources in terms of increase or better targeting to explain the changes. Among those who felt that services had deteriorated, resources accounted for 49% of comments (125/254) and two thirds of the group were doctors. Surgical specialties seemed to feel the impact of resource pressures particularly acutely, e.g.

> *Manager (1538) (Response to 6a: Worse) With regard to emergency patients resources not available to meet demand, beds blocked by social services patients, knock on effect to elective beds, cancelled operations etc.*
>
> *Consultant (1680) (Response to 6a: Worse) Loss of surgical beds, staff and operating lists*

Resources was the most important single category to doctors since 24% (132/552) couched their comments in these terms compared to 14% (106/762) of managers. 65% (86/132) of doctors in this category believed that services had deteriorated, and resources account for more than half (86/160) of doctors' overall set of explanations for poorer services. Managers,

on the other hand, take a more positive view with 56/106 (53%) linking resource issues to improved services. e.g.

> *Consultant (2807) (Response to 6a: Worse) Multifactorial - less resources, more demand, poorer nurses, less commitment of staff to patient care, changing practices of junior hospital doctors*
>
> *Manager (1113) (Response to 6a: Better) The service in my specialty has benefited by an additional £1.2 million, although the directorate negotiates direct with the purchaser. Without a directorate structure I doubt the needs of psychiatry would be pushed up the corporate agenda.*

9.2.4 Quality Factors

Table 9.12: 6b Responses Linked to 6a Ratings: Quality Factors

5a Ratings :	Much Worse	Worse	No Change	Better	Much Better	Total
Doctors	1	15	5	66	4	91
Managers		4	2	75	11	92
Total Quality Factors	1	19	7	141	15	183

Figure 9.12: 6b Responses Linked to 6a Ratings: Quality Factors

Quality factors overlap to some extent with the *customer care* category and relate also to Resources. Responses were coded to the *quality* group if the first comment identified a specific factor such as complaints or waiting lists or covered the issues identified in the sub-groups earlier. 14% of comments were coded to *quality* factors, and these were weighted towards improvements in service: 17% (156/897) of responses associated with improvements fell into this category compared to 8% (20/254) of comments identified with deteriorating services.

17% of doctors (91/552) and 12% (92/762) of managers highlighted special quality issues, in which 96% (70/91) of doctors and 96% (88/92) of managers believed services had been improved through these changes.

The verbatim comments show how the coding structure underestimates the contribution of, for example, complaints handling or waiting lists since the coding picks up the primary, i.e. the first, main topic identified, even where an inventory of other factors follows, e.g.

> *Manager (1430) (Response to 6a: Better) More emphasis on patients through communications, attention to complaints, improved waiting times, growth in the number of consultants, many quality awards.*

9.3 Question 9. Do you think the NHS climate will change with the new government?

Both groups thought that there would be some change, although doctors were the most sceptical about the degree of change with 31% feeling there would be little change compared to 12% of managers.

Table 9.13: Responses to Question 9

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 No - there will be little change	206	*30.8%*	102	*11.5%*	308	*19.8%*	*19%*
2 Yes - there will be some change	390	*58.3%*	602	*67.9%*	992	*63.8%*	*-9.6%*
3 Yes - significant change	73	*10.9%*	182	*20.5%*	255	*16.4%*	*-9.6%*
Count	669	*100%*	886	*100%*	1555	*100%*	
Mean Rating	1.80		2.09		1.97		

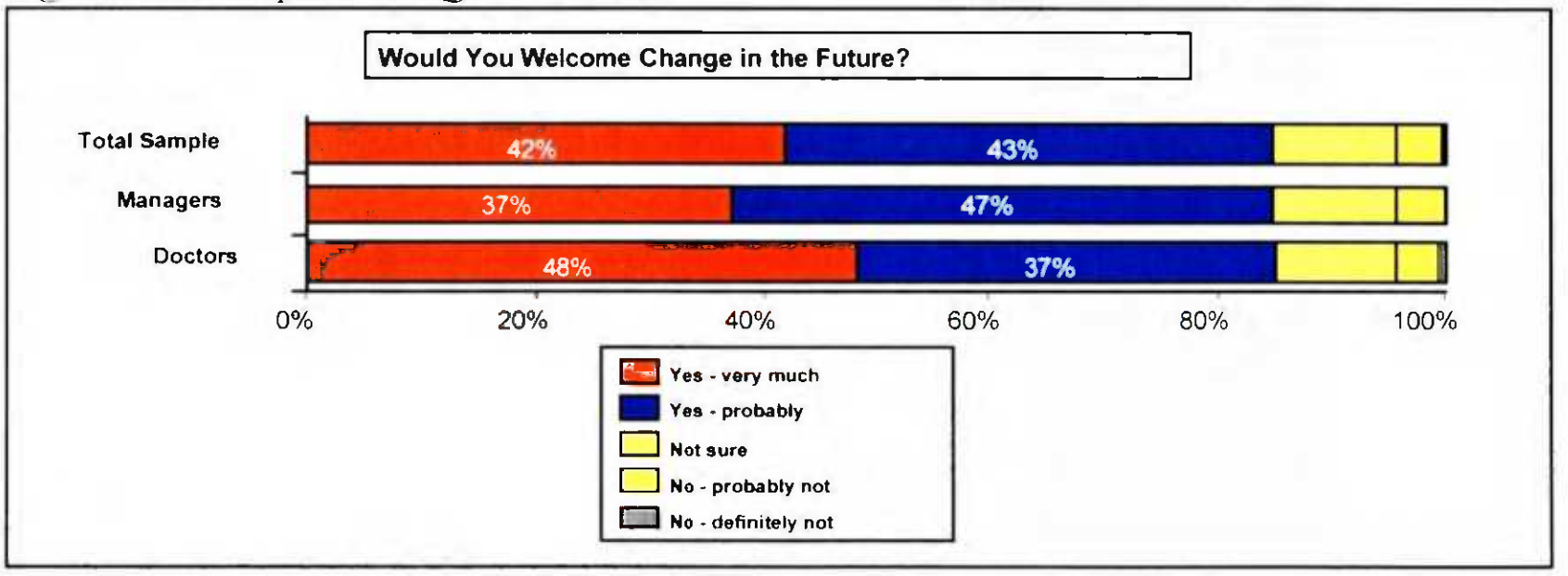
9.4 Question 10a. Would you welcome change in the future?

There was a strong appetite for change among both doctors and managers, with greater intensity in favour of change among doctors. This is notwithstanding the responses to Questions 5 and 6 in which the two groups indicated that both relationships and services to patients had improved over the period since Trust status.

Table 9.14: Responses to Question 10a

	Doctors		Managers		Total Sample		Doctor-Manager Difference in % Points
1 Yes - very much	322	*48.1%*	329	*37.3%*	651	*42.0%*	*11%*
2 Yes - probably	249	*37.2%*	417	*47.3%*	666	*42.9%*	*-10%*
3 Not sure	71	*10.6%*	98	*11.1%*	169	*10.9%*	*0%*
4 No - probably not	24	*3.6%*	36	*4.1%*	60	*3.9%*	*-1%*
5 No - definitely not	4	*0.6%*	1	*0.1%*	5	*0.3%*	*0%*
Count	670	*100%*	881	*100%*	1551	*100%*	
Mean Rating	1.71		1.82		1.78		

Figure 9.13: Responses to Question 10a



9.5 Question 10b & 10c. Why would you welcome change in the future and what sort of change would you like?

This section of the question provided about four inches depth of writing space and some individuals used it to make lengthy comments or lists of factors. Unlike the the other open questions (5b) and 6b) where the primary explanation was used for coding purposes, in this question every piece of material has been used and coded. Up to six separate aspects of change were identified per individual.

9.5.1 Coding Mechanism

Responses have been structured within ten umbrella headings for change and up to twelve sub-headings in a single category have been identified during the coding process. The total count was 2,791 factors (equivalent to 1.8 factors for each respondent in the 1,577 sample base) organised according to the summary in Table 9.15 and itemised in Figure 9.14.

Figure 9.14: Responses to Questions 10b and 10c

Open Question Coded Responses to Question 10 - What sort of change would you like to see and why?

10 Reduce Bureaucratic Process	*10 Count*	20 Resources (inc Staffing)	*20 Count*	30 Priorities	*30 Count*	40 Influence	*40 Count*	50 Market	*50 Count*	60 Service Configuration	*60 Count*	70 Structure	*70 Count*	80 Technology, Staff & Facilities	*80 Count*	90 Government/ Public	*90 Count*	100 Motivation/ Local Working Practices	*100 Count*
10 Bureaucratic Process	154	20 Resources	7	30 Priorities	20			50 Market	5	60 Service Configuration	10	70 Structure	4	80 Technology, Staff & Facilities	35	Honesty/ openness, debate about affordability & rationing priorities. Realistic approach to costs. Good healthcare costs	123		
(a) Eliminate management/ transaction costs/ measurement Change management structure Redirect £ to patient care	47	(a) Increase level. Set at more realistic level	222	(a) NHS philosophy of universal provision & public service ethos. Quality & clinical need of patient first, irrespective of origin. Removal of business thinking/freedom of choice/ freedom of choice	135	(a) Less managerial & more consultant/ professional/ clinical input	50	(a) Abolish GPFH/ two tier	81	(a) Rationalisation/ mergers/ reconfiguration/ integration	77	(a) Need more centralism, e.g. regional planning	25	(a) Develop	10	(b) More energy	3	(a) Current system demoralising/ tired/ pressured	45
(b) Internal market expensive/ overly complex/ paper chasing	42	(b) Use e.g. efficiency, skill mix, cost effectiveness	25	(b) Spending	22	(b) Less purchaser	24	(b) Abolish internal market/ purchaser-provider split. Efficiency is not rewarded so it needs removal or rehabilitation	97	(b) Remove duplication	16	(b) Directorate structure bad	2	(b) Better quality staff & training	9	(a) Better leadership/ clarity	34	(b) Too much change and meddling. Needs stability. Change takes up too much energy	37

Figure 9.14: Responses to Questions 10b and 10c

Open Question Coded Responses to Question 10 - What sort of change would you like to see and why?

10 Reduce Bureaucratic Process	*10 Count*	20 Resources (Inc Staffing)	*20 Count*	30 Priorities	*30 Count*	40 Influence	*40 Count*	50 Market	*50 Count*	60 Service Configuration	*60 Count*	70 Structure	*70 Count*	80 Technology, Staff & Facilities	*80 Count*	90 Government/ Public	*90 Count*	100 Motivation/ Local Working Practices	*100 Count*
(c) Drivers e.g. efficiency index. Perverse incentives	6	(c) Equity/ access	75	(c) Rationing - accept demand vs funding **Links to 20c and 40c**	31	(c) Set priorities which are evidence-based/ health gain	30	(c) Internal market not working/ messy/ fragmented/ not meeting objective. £ is not following the patient. Needs amending	119	(c) Speed up major service changes & development ability	7	(c) Consider/ review regional outposts	2	(c) Employment contracts	6			(c) More co-operation (& less competition)	156
(d) Contractual arrangements e.g. long term	96	(d) Capital availability/ PFI	14	(d) Clinical standards/ effectiveness/ audit	53	(d) Improve purchaser quality/ understanding/ performance	48	(d) Competition is a problem	75	(d) Dealing with emergencies	12	(d) NHS/SS/ multiagency	49	(d) Nursing staff - appreciate importance	12			(d) Goood practice/ collaborative care planning	6
(e) More meaningful measures	11	(e) Backlog maintenance	2	(e) Conflicts: break-even emergencies, waiting times	15	(e) Informed Users. Involves focus	9	(e) Abolish Trusts	4	(e) Effective SS	2	(e) Long term/ strategic planning	66					(e) Time for patient	1
		(f) Contract out consultants	1	(f) Quality & financial balance	9	(f) Less consultant influence/ intransigence	23	(f) Abolish HA purchasing role	7	(f) Development of primary care services	18	(f) Abolish regions	1					(f) Change is good/ stimulating	10
		(g) Review funding arrangements	57	(g) Higher volume/ throughput. Reduce revenue restrictions on activity	4	(g) More GP clarity. Better relationship	15	(aa) Amend GPFH	50	(g) Trust freedom to develop services	11	(g) Streamline whole purchasing structure/ commissioning groups	63					(g) Increase job satisfaction/ security/ motivation. Staff to feel valued	27
				(h) Pragmatism	4	(h) Clinicians in management & planning, inc. Board involvement	20	(ab) Closer links with GPFH	1	(h) Waiting list management	3	(h) Partnerships with private healthcare	2					(h) Change unlikely to make improvements	2

Figure 9.14: Responses to Questions 10b and 10c

Open Question Coded Responses to Question 10 - What sort of change would you like to see and why?

10 Reduce Bureaucratic Process	*10 Count*	20 Resources (inc Staffing)	*20 Count*	30 Priorities	*30 Count*	40 Influence	*40 Count*	50 Market	*50 Count*	60 Service Configuration	*60 Count*	70 Structure	*70 Count*	80 Technology, Staff & Facilities	*80 Count*	90 Government/ Public	*90 Count*	100 Motivation/ Local Working Practices	*100 Count*
				(j) Reasonable targets, e.g. Patients Charter. **Links to 60h**	18	(j) Local control, inc Directorate	22	(ac) Total Fundholding	3	(j) Trust = good	8	(j) Abolish or reduce private practice	6					(j) Concern that changes made by this government would reverse improvements	7
				(k) Volume control	2	(k) Better management, organisation & leadership	31	(fa) Review and amend HA-provider relationship	41	(k) GP culture: Control primary care demand. Control the shift in balance of resources to primary care	25							(k) Appreciate managers	7
				(m) More business like	2	(l) Education & information to staff, patients, managers	2	(fb) Keep purchaser/ provider split	6	(k) Public health - not necessarily current public health function	1							(m) Less litigation	2
								(g) Locality base	12										
Total	*356*	*Total*	*403*	*Total*	*315*	*Total*	*274*	*Total*	*501*	*Total*	*190*	*Total*	*220*	*Total*	*72*	*Total*	*160*	*Total*	*300*

Grand Total 2791

Table 9.15: Inventory of Responses to Questions 10b and 10c

Code	Main Category	Doctors	%	Managers	%	Total	%
10	Reduce bureaucratic process	100	*8%*	256	*16%*	356	*13%*
20	Resources (including staffing)	197	*16%*	206	*13%*	403	*14%*
30	Priorities	135	*11%*	180	*11%*	315	*11%*
40	Influence	137	*11%*	137	*9%*	274	*10%*
50	Market	224	*19%*	277	*17%*	501	*18%*
60	Service Configuration	77	*6%*	113	*7%*	190	*7%*
70	Structure	79	*7%*	141	*9%*	220	*8%*
80	Technology, Staff and Facilities	41	*3%*	31	*2%*	72	*3%*
90	Government/Public	79	*7%*	81	*5%*	160	*6%*
100	Motivation/Local Working Practices	126	*11%*	174	*11%*	300	*11%*
	Total	1195	*100%*	1596	*100%*	2791	*100%*

The strongest message to emerge from this question was a desire for reform or abolition of the internal market, which is in keeping with the new Labour Government's subsequent policy.

9.5.2 Main Categories

Five broad headings accounted for two thirds of responses, described as 'the market', 'resources', 'reduce the bureaucratic process', 'priorities' and 'influence'. There is a strong degree of overlap in the meaning behind these comments. Complaints about the market, for example, are motivated in large measure by a feeling that resources are being misdirected towards wasteful bureaucratic processes due to wrong-headed priorities. The categories of priorities and influence overlap where respondents feel that professional and clinical influence is overruled by financial and market-led priorities. Nevertheless it was possible to isolate responses into 73 sub-categories which were coded within ten main topic headings.

The largest single area, described as 'the market', accounted for 18% (501/2,791) of topics raised. Within this the emphasis varied, with the largest group (119/501- code 50c) calling for changes to the internal market, arguing that it was not working, was messy and fragmented and was not meeting its objective since money was not following the patient. A slightly smaller but significant number (97/501 - code 50b) argued that the internal market should be abolished. The dividing line between the two categories is not altogether clear because calls for abolition are qualified with comments such as *efficiency is not rewarded so it needs removal or rehabilitation.* Some comments had a degree of internal inconsistency where there were calls for abolition of the market but retention of the purchaser-provider split, and vice versa. Nevertheless the responses indicate the mood of respondents. The comment below shows how a feeling that the internal market system was not working well led to a feeling of waste in the cost of running it:

Consultant (1478) The present system is not working well. The fundamental provider and purchaser philosophy costing the health service a lot of money. As a result the people who are doing clinical work not getting enough pay - causing dissatisfaction. Top heavy unnecessary administration costs money. GPs are a non-homogeneous group, although they are branded totally 'purchaser' they are not functioning adequately. More money and motivation will be necessary.

81 (code 50b) individuals called for abolition of GP Fundholding and the two tier purchasing split while 50 made the less specific suggestion that GP Fundholding should be amended (code 50aa). 70 people (code 50d) argued that competition was a problem in the context of market structure, which links closely to the category of responses described as 'motivation/ local working practices', accounting for 11% of the sample (300/2,791), in which 156 people (code 100c) called for more co-operation and less competition in local working arrangements with other health colleagues. This subsequently became the underlying theme of government policy in the White Paper which was published two months after this survey was undertaken.

16% of doctors' and 13% of managers' comments highlighted resource issues, mainly in terms of the need for an increase and for resources to be set at a more realistic level (code 20a) e.g

Consultant (1456) We need to accept that the current funding of the NHS has been similar to a 'chain letter' and we are reaching the end of the chain.

57 people (code 20g) recommended that funding arrangements should be reviewed and 75 people (code 20c) called for improvements in access and equity of provision through targeting of resources. This linked with 30c) in which 31 people called for priorities to be set according to a form of rationing which accepts the gap between demand and funding, and with 40c) in which 30 people indicated that priorities should be set which are evidence-based and geared towards health gain, e.g.

Manager (1113) Welcome a united view of service development that is based on informed purchasers/GPs taking account of evidence-based medicine rather than confrontational stories.

The question of resources linked to the area described as 'government/public' in which 123 respondents (code 90) called for an open debate by Government about the affordability of services and rationing priorities. The word *honesty* was invoked in this context and a call for a realistic approach to costs, arguing that *'good health care costs', e.g*

Consultant (1365) The current system is demoralising and demotivating. A little honesty from the government to the people would help - like an admission that there is not enough money in the nation to pay for the Patient's Charter would be a start.

13% of comments (356/2,791) pressed for a reduction in bureaucracy, with some specific suggestions directed towards long term contractual arrangements, e.g.

> *Consultant (1130) Too much paper pushing; longer service agreements with less checking of individual service episodes would release energy to do more constructive things. Main obstacle - 6 years of competition between organisations cannot change overnight.*

Bureaucracy was described in terms of transaction costs which should be eliminated and management costs which should be reduced through changes to the management structure and redirection of resources to patient care.

11% (315/2,791) of responses identified a need for a change in NHS priorities, described as a return to the NHS philosophy of universal provision and public service ethos, putting quality and clinical need of the patient first, irrespective of origin, and removal of business thinking to be replaced by freedom of choice. This set of comments pinpointed the need for a return to a value system which many felt had been eroded and was shared by doctors and managers alike. This was in contrast to a small number of comments (2/2,917, code 30m) which called for a more business like approach and 7 (code 100j) which revealed concern that changes made by the new Labour Government would reverse improvements made by the 1991 reforms.

10% of responses (274/2,791) sought a change in influence, with 50 individuals (code 40a) calling for greater professional and clinical input as against 23 (code 40f) who wanted to reduce consultant influence and intransigence. The flavour of most comments worked towards restoring clinical input, with a move towards evidence-based decisions based on health gain, greater involvement of clinicians in management and Board decisions, and an improvement in the quality of purchaser understanding and performance.

8% of comments (220/2,971) related to structural issues, the main one of which (66/220, code 70e) identified a need for longer term and strategic planning with a further 25/220 (code 70a) looking for greater centralism and regional planning.

Service configuration accounted for 7% (190/2,791) of comments, with 77/190 advocating rationalisation through merger and service integration.

9.5.3 Passion !!

Questions 10b and 10c provided respondents with an opportunity to give a detailed account of their views. Some respondents brought a high degree of passion and commitment to their responses, with liberal use of exclamation marks and other means of emphasis. Four comments are quoted below, partly to show the range and quality of responses. It also allows the final word in this area to the consultants and managers who participated in the exercise:

Consultant Anaesthetist - Chair of Clinical Directorate (4399) - Responses : No- there will be little change; Yes - very much welcome change.
Why? I cannot face 10 more years working at the rate I am doing, carrying responsibility for everything from increasing service and keeping waiting lists down to being liable for deficiencies in my colleagues' work/teaching medical students/postgrad trainees/paramedics while keeping a smile plastered to my face in case outsiders think that something is wrong in our Trust and our image is ruined.

Manager (1469) Reduce purchaser bureaucracy and give Trusts greater freedom to develop local services. Reduce power of GPs, improve standard of GP services and remove their ability to make money out of the system, whilst bleeding secondary care to death!

Corporate Manager - Head of Community Services Directorate (4819) - Responses : Yes - there will be some change; Yes - probably welcome change.
I would like to see a move away from purchasing/providing split which I find practically and culturally prohibitive to creativity and innovation. I would like to see Primary Care Led NHS mean something other than expecting busy GPs converted to accountants. I would like to see a return to the emphasis on prevention of ill health as the focus of community service and I would like to see significant changes to remove the demarcations between health and social care. I would like to see the abolition of Eligibility Criteria which perpetuate these demarcations and I would like to see evidence of needs led practice rather than the clerically contrived administrative bureaucracy currently inhibiting dynamic health and social care. I would like to see Health Authorities merged into larger strategically focused organisations and I would like to see change managed by coalition and collaboration rather than through crippling mergers of Trusts. Thank you for asking!

Consultant in Accident & Emergency (3378) Responses : No- there will be little change; Yes - very much welcome change.
Get rid of the stupid internal market. NHS is a "single company" with no competitors so how can you have a market. Illness in Inverness the same as Illness in Illchester. Allow consultants more say in managing the NHS. We are supposed! to be the top output of our Universities. There is a lot of talent available. Get rid of financiers and auditors like Coopers & Lybrand, KPMG. They have NO idea about health only businesses like BT etc. Get rid of stupid league tables and childish star systems. There are improvements and saving to be made, efficiencies to be gained but not the way as now. We need More NURSES and a few more Doctors, Phlebotomists, Porters, Receptionists, clerks and Medical secretaries! The pistons of the NHS Engine!!! Patients are the petrol!!! Many managers in Health Authorities have no idea about health care needs. A doctor and a nurse enters the NHS from 18-20 years through to 65 years old. It's our LIFE, not just a job as it is for the Business executives!!

9.6 Conclusion

The open questions had been developed initially to enhance the design of the questionnaire with no preconceptions about the likely coherence or otherwise of responses. In the event, these questions provided a rich set of data yielding a high degree of consistency in the explanations given to describe changes in relationships and services. Trust status on the whole was perceived to have brought consultants and managers to a shared view of the world, helped by engaging clinicians in the management process. Benefits to patients had been realised, it was felt, through greater responsiveness and an awareness of the patient's perspective. The responses evoked a sense that Trusts had adopted a greater degree of self-determination and a clearer approach in trying to improve services to patients. At the same time, there was a strong desire for change and a clarion call to dismantle the internal market. The White Paper, published two months after the survey period, addressed this desire for greater co-operation and partnership and restoration of a public service ethos, without rejecting Trust status.

Some individuals, particularly consultants, made colourful and rather heartfelt responses which betrayed a degree of stress, anger and, in some cases, despair which under the statistical aggregation of closed question responses would be concealed. These sentiments were consistent with the feeling that clinical views ought to have greater prominence, with a shift of control in the future from managers to doctors, articulated in the response to Question 10.

The analysis of closed questions in Chapter 7 reveals an instinct on the part of respondents that doctors, in the longer term, would be more successful in achieving their goals than managers. Question 3, asking which group is believed to be achieving their objectives, shows that managers are perceived to dominate in the short term but that the balance of power will shift to consultants in the long term. This moves in the same direction as the appetite for change highlighted in this chapter. During the period in which this questionnaire was completed (September-October 1997) it was known that a new government policy was about to be announced. This is reflected in the response to Question 9 in which 80% of respondents believed that there would be some form of change in the NHS climate due to the (then) new Government. In Question 10, 31% of people sought removal of bureaucracy and internal market mechanisms and 20% sought a change of direction towards higher priority for clinical needs of patients and a less financially-driven set of goals. On balance there was a call for greater clinical/consultant input and a reduced managerial influence.

The implication is that pressure of opinion exists within Trusts to weaken the financial strictures imposed on them since, according to the responses analysed in this chapter, the orientation of Trust objectives towards *financial break-even* is an unpopular feature. The results of Question 10 shed light on the results of Question 2 analysed earlier in which all groups of individuals appeared to be alienated from the priorities of Trusts which were felt to be unequivocally driven by financial goals.

The results of the open questions indicate that the apparently clear objectives of Trusts will be eroded in practice by the force of opinion of doctors and managers working within them. The distance between the perceived aims of Trusts and those of individuals (Question 2) indicates a divergence between the formal goals and the real motivation of Trusts. The role of managers as financial controllers was put in doubt by the responses of service/business managers analysed earlier, which indicated that the budgetary constraint could be weak in the face of service demands. The qualitative responses put forward in this chapter reinforce this lack of conviction that financial targets should be met.

The purpose of the next chapter is to test the financial performance of Trusts to examine whether service constraints override financial priorities in practice.

CHAPTER 10. TRUST PERFORMANCE

Chapters 5-9 dealt with the first and most detailed line of enquiry which studied motivation of Trusts through an attitudinal survey. This chapter considers the actual behaviour of Trusts through an analysis of financial and service performance, using a quantitative approach which corresponds with 'method 2' described in Chapter 4 earlier.

It is perhaps worth repeating the hypotheses which were formulated in Chapter 4 and are tested in this chapter. These hypotheses evade the strong testing conditions of static equilibrium analysis (SEA) by considering the weaker hypothesis that clinicians aim to expand rather than maximise their service in the short term. Break-even is tested through the 6% financial target since the 6% return on assets is set to match the target break-even position for the Trust.[24]

1A Doctors aim to expand their service. Volume is used as a measurable proxy, but in reality service means a combination of volume and quality.

2A Managers aim to break-even, measured through the Financial Target Performance of 6% pre-interest return on assets.

3A In 'good times' these objectives will converge to form a Trust objective of service expansion subject to a break-even constraint.

4A In 'bad times' objectives of doctors and managers will diverge. The Trust will not have a unified objective. It is hypothesised that doctors will emerge as the dominant group in the long run so that the Trust pursues service expansion and does not achieve the break-even constraint.

Chapters 5-9 dealt with hypotheses 1 and 2 by trying to explain the motivation of doctors and managers, the principal actors within hospitals. The study summarised in this chapter deals with hypotheses 3 and 4.

10.1 Sample

A sample of 100 acute hospital Trusts has been selected in order to examine movements in volume and income between the financial years 1993/4 and 1994/5 (Fitzhugh, 1996). Selection criteria for this exercise were applied as follows:

- first, second and third wave Trusts are included. Fourth wave Trusts are excluded because no data was available for 1993/94.

- only general acute Trusts are included, i.e. Trusts which are coded as Category

[24] Annual accounts show actual income and expenditure and give a figure for operating surplus and retained surplus (after interest). The NHS Executive has flexibility to adjust interest repayments downwards if the actual operating surplus is below the target return; in other words, the Trust may show a balanced post-interest budget while failing to meet the Financial Target Performance.

2 in the Fitzhugh Directory of Annual Accounts. This enables episodes to be used as a simple measure of output. (A mixed Trust with community elements would have required a different unit of activity measurement, e.g. district nurse contacts).

The selected output measure is finished consultant episodes. This was extracted first of all from the published annual accounts but, since Trusts publish this activity information at their discretion, there was no uniformity of structure and 56% of Trusts presented no activity data. A second source of national data was then used instead (Department of Health 1993c, 1993d, 1994, 1995).

10.2 Possible Outcomes

In terms of the hypothetical objectives of doctors and managers, which may or may not converge, there are four possible outcomes which can be measured through service and financial data. These are described as: Type 1, Win-Win, where both financial targets are achieved and volume is increased, enabling both managers and doctors to achieve their objectives; Type 2, where managers win by achieving the financial target performance (FTP) but volume reduces; Type 3 where doctors win by pushing up service volumes but managers fail because the Trust does not achieve its financial target; Type 4 where both parties lose because the Trust fails to break-even and service volume is reduced. The figure below summarises these typologies.

Figure 10.1: Possible Outcomes Linked to Hypothetical Objectives

Outcome	6% FTP (Break Even) *Managers' Aim*	Expanded Output *Doctors' Aim*	Shorthand
Type 1	☑	☑	*Win-Win*
Type 2	☑	☒	*Managers Win*
Type 3	☒	☑	*Doctors Win*
Type 4	☒	☒	*Lose-Lose*

10.3 Partial and Full Sample

Two exercises were conducted to find out how Trust behaviour was distributed across these four types. In the first exercise, which drew on annual accounts, activity data was absent for 56% of Trusts, limiting the sample to 44 hospitals. The second exercise introduced activity data from a separate source published by the Department of Health (1993c, 1993d, 1994, 1995) which enabled the full sample of 100 Trusts to be analysed. The results are summarised in the table below and they show that the missing data did not produce any systematic bias in the first exercise since the distribution of results was similar for both. The

missing data, for example, might have been masking poor service performance in 56 Trusts and so could have been split between Type 2 and Type 4 results. Exercise 2 shows that this is not the case since the distribution of types between 100 Trusts follows the same pattern as for the 44 Trusts.

Table 10.1: Distribution of Results between Types

	Exercise 1 Trusts	%	Exercise 2 Trusts (=%)
Type 1	29	66%	63
Type 2	4	9%	6
Type 3	11	25%	28
Type 4	0	0%	3
Sample Total	44	100%	100
Missing	56		0
Total	100		100

10.4 Trust Performance and Financial Environment

The results have been analysed in two groups : (i) Trusts which received an increase in revenue and (ii) Trusts which received reduced revenue. The results of both exercises, splitting the sample into revenue increasing and revenue reducing sets, is summarised in Figure 10.2. In situations where revenue is reducing there is an increase in the proportion of Type 3 where doctors win and a reduction in Type 1 where both managers and doctors win.

Table 10.2: Summary of Results according to Financial Environment

		Exercise 1 (n=44)			Exercise 2 (n=100)		
		£ Up	£ Down	All	£ Up	£ Down	All
Type 1	Win-Win	73%	45%	66%	67%	55%	63%
Type 2	Managers Win (>=6%)	6%	18%	9%	6%	6%	6%
Type 3	Doctors Win (Volume Rise)	21%	36%	25%	25%	35%	28%
Type 4	Lose-Lose	0%	0%	0%	3%	3%	3%
Sample	n =	33	11	44	69	31	100

Figure 10.2: Trust Performance within Financial Environment of Growth or Constraint

Income Change Group	Financial Target Performance	Output Change (Episode)	*Typology*	% of Group
£ INCREASED 69 Trusts	>=6% 50 Trusts	Increased Volume 46 Trusts	*Type 1*	*67%*
		Reduced Volume 4 Trusts	*Type 2*	*6%*
	< 6% 19 Trusts	Increased Volume 17 Trusts	*Type 3*	*25%*
		Reduced Volume 2 Trusts	*Type 4*	*3%*
£ REDUCED 31 Trusts	>=6% 19 Trusts	Increased Volume 17 Trusts	*Type 1*	*55%*
		Reduced Volume 2 Trusts	*Type 2*	*6%*
	< 6% 12 Trusts	Increased Volume 11 Trusts	*Type 3*	*35%*
		Reduced Volume 1 Trusts	*Type 4*	*3%*

Another way to consider these results is by grouping the occasions when managers win (Types 1 and 2) and comparing with the occasions when doctors win (Types 2 and 3). The table below shows that the objectives of doctors, as set out in the hypotheses, tend to dominate even though managers succeed in achieving their aims in more than half of all cases in each group. Where there is a reduction in income compared to the previous year then both

doctors and managers achieve a lower total degree of success, but the reduction in the proportion of manager wins is greater than the reduction in the proportion of doctor wins.

Table 10.3: Summarising Managers' and Doctors' Wins

	Exercise 1 (n=44)			Exercise 2 (n=100)		
	£ Up	£ Down	All	£ Up	£ Down	All
Managers Win (Types 1 and 2)	79%	63%	75%	73%	61%	69%
Doctors Win (Types 1 and 3)	94%	81%	91%	91%	91%	91%

10.5 Interpreting the Results

The results of this study need to be considered in relation to the hypotheses and compared with the results of the questionnaire survey set out in the previous chapters.

10.5.1 In Relation to Hypotheses

The results are consistent with the hypotheses in that two thirds of Trusts which experienced revenue growth also succeeded in achieving both their financial target and a growth in service delivery. In these revenue-gaining Trusts managers failed in their postulated objective 27% of the time while doctors failed only 9% of the time. Where Trust income contracted, managers failed to meet the financial target in 39% of Trusts while doctors saw output reduction in only 9% of cases. To put it another way, where income reduces, i.e. in the 'bad times', then managers experience greater difficulty in achieving the financial target performance; the service continues to expand at the expense of financial constraints. The most striking result is that, while doctors and managers each succeed in achieving their objectives in the majority of cases, both where income is rising and where income is reducing, this does not invalidate the conclusion that, where the aims of doctors and managers are mutually exclusive, doctors' behaviour will tend to prevail. The results lend support to hypothesis 4A which suggests that doctors will emerge as the dominant group over time, overriding the management objective, postulated in hypothesis 2A, of meeting budget constraints.

10.5.2 In Relation to the Questionnaire Survey

The summary of responses set out in the previous chapter suggested that service volume was less important to clinicians than quality, indicating that doctors' primary motivation was based on quality of the service. This does not invalidate the hypotheses expressed here in terms of volume since consultants still observed this to be more important to them than financial targets. The mean rankings showed consistency between consultants' view of themselves, consultants' view of other consultants and managers' view of consultants. The

order of priority was determined as: (1) maintaining quality, (2) expanding quality, (3) maintaining volume, (4) expanding volume, (5)/(6) expanding revenue/breaking even. Hypotheses 1A-4A and the associated test remain valid in the light of the questionnaire responses. The questionnaire results suggest also that the hypotheses and corresponding test would be stronger if related to quality but, given the difficulties in measuring quality at a global level, the secondary objective of service volume is adequate as a counter-objective to financial break-even[25] .

10.6 Conclusion

This empirical study is a pragmatic review of service and financial performance in 'good times' where income is rising and in 'bad times' where income is falling and service reductions could be expected to be meted out. It tests the probability of outcome-combinations and finds that Trusts expand their service more often (91% of occasions) than they meet financial targets (69% of occasions). This service objective is associated with doctors through the hypotheses and the attitudinal survey, and so the results of this exercise are consistent with Hypothesis 4A that doctors' priorities dominate those of managers.

The findings of earlier chapters have been used to test Hypotheses 1A and 2A relating to motivation of groups within Trusts. The results of the quantitative test in this chapter support Hypothesis 4A, i.e. that doctors will be dominant within Trusts, only in so far as the underlying motivation of doctors and managers has been correctly discerned. The questionnaire attitudinal survey produced results for consultants which were consistent from every perspective. Both doctors and managers perceived this group as being interested primarily in service quality, followed by service volume, with financial control ranking as least important to them. The motivation of managers proved to be more complex. The group overall conformed with Hypothesis 2A by identifying *financial break-even* as their most important goal. Within this group, however, there is a spectrum of seven categories: Chair, CEO, Board Director, Corporate Managers, Service/Business Manager, Other Manager (which according to job titles within the questionnaire responses comprised mainly service/business managers) and Clinical Professional. The groups closest to service provision or the operating core are the last three, comprising 51% (458/896) of managers who responded to the questionnaire survey (Table 7.2). The other groups of managers are located at the centre of the organisation and, in the case of Board members, at the apex or most senior level within Trusts. The pattern of responses varied between these two broad categories, with service and clinical managers showing a strong drive towards service quality goals while still observing break-even as a constraint. Their responses fell part way between those of consultants and the senior/corporate group of managers who had a clearer focus on *financial break-even* as an objective. The equivocation of service managers has the effect of weakening the assumption

[25] Depth of service in terms of investigations, technology and other levels of care associated with a single episode provides a possible method of framing quality in relation to volume and finance. Where extra funding is invested in this way rather than in expanding the service it could be argued that the hypothesis of quality taking precedence over quantity is supported.

that managers have a clear set of objectives which are independent of those of consultants. Instead, this group may be seen as colluding with consultants in opposition to the goals of the Trust as a whole which are clear to all groups as being financially driven.

Lukes' study of power (1974, discussed in Chapter 3) highlighted Polsby's argument (1963) that power or control can best be observed in situations where there is an observable conflict of interest. Where there is no conflict, as in the 'good times' postulated in Hypothesis 3A, there is no test of relative strength. Hypothesis 4A, therefore, sets the conditions under which doctors and managers can be seen to compete for control. The competition, such as it is, appears to be won more often (i.e. lost less frequently) by consultants. Managers struggle to achieve their overall aim of financial control in the face of conflict.

In summary, the performance of Trusts in this chapter, which can be interpreted as producing financial failure more often than service failure, is consistent with the aims of doctors (Hypothesis 2A). It is also consistent with medical dominance (Hypothesis 4A) in so far as managers fail to achieve their own goal. However, this medical dominance could be determined by a reluctance on the part of managers to be single-minded in managing the budget, rather than a show of strength by doctors.

CHAPTER 11. COMPETITIVE ENVIRONMENT: A CASE STUDY

The third line of enquiry uses a case study to follow events 1991 to 1998 within the health economy of south west London. Kingston Hospital is the main case study site but the sequence of events incorporates dynamics between Kingston and its neighbouring hospitals, Epsom and Queen Mary's.

A descriptive case study of this nature permits some analysis of the behaviour of Trusts in a market environment. In this external environment Trusts receive feedback on their performance through interaction with purchasers and other providers and, to this extent, corresponds with the final element of the motivational process outlined in Chapter 3 which reviewed the psychological literature. At the close of the literature survey it was remarked that a competitive market does not appear to have developed in the NHS and that the external incentive structure may play a part in shaping the goals of the principal actors. Feedback from market behaviour provides a mechanism for shaping motivation.

11.1 Overview

The market reforms of 1991 satisfied certain conditions of a competitive market necessary to achieve efficiency. The government injected a financial component into the motivation of Trusts through strict financial targets and introduced a competitive contracting environment through the purchaser/provider split. Legislators, however, had limited control over the fundamental market structure which determined the behaviour of Trusts/firms since political and community interests act as a formidable external constraint to any market exit. The survival instinct of Trusts, stimulated by the competitive market regime, coincides with the local community's desire to defend its own hospital. As a result hospital closure is difficult and politically distasteful and produces a block to market forces.

The Kingston case study supports this analysis. It shows how, in the first place, Kingston Hospital embraced the notion of competition, particularly in relation to neighbouring Epsom Hospital, and goes on to show how barriers to exit dominated the market structure, fuelled by political interests, community reactions and organisational 'survival' behaviour on behalf of Queen Mary's Hospital.

This case study provides a chronology of events, derived from a search of files at Kingston Hospital and supplemented by interviews with key personnel.

11.2 Description of Case Study Sites

Kingston Hospital is a medium sized (approximately 400 beds) district general hospital with an annual budget of £50 million (Fitzhugh, 1997). It became an NHS Trust as part of the first wave from April 1991. Epsom Hospital Trust also joined the first wave and is located

approximately six miles south of Kingston. A third hospital, Queen Mary's Hospital Roehampton, is located four miles to the north of Kingston and was part of the fourth wave Richmond, Twickenham & Roehampton Trust.

All three hospitals are part of a health economy which covers south west London and part of Surrey and which mimics central London in its problems of overcrowding in the acute hospital sector (Tomlinson, 1992). St George's, St Helier, Epsom, Queen Mary's, West Middlesex, Charing Cross and Chelsea & Westminster each lie within a radius of seven miles. Financial problems led purchasers to find some means of reducing hospital costs and rationalising services. This is relevant to both aspects of the case study in setting the scene of sustained pressure on acute services in the area.

Kingston hospital developed a reputation for innovation and efficiency, partly through use of day surgery. It opened one of the first surgical day units in the country in 1979 in a successful attempt to deal with the effect of closure of a general surgical ward. In 1991 a hospital hotel was opened, owing to another initiative by the general surgeons, to receive patients who were medically fit to be discharged from hospital but who lacked home support. This enabled patients to be treated as day cases who, perhaps because they lived alone or in a tower block with a broken lift, would otherwise be admitted as inpatients. The business plan for 1995/96 noted that the Trust's activity of 32,000 episodes represented a '*high ratio of episodes to beds (90:1)... achieved by making extensive use of day surgery.*' The business plan for 1996/97 again highlighted Kingston's high level of productivity: '*National performance indicators have consistently shown the hospital to be very productive compared to other acute units and to have relatively low unit costs. Recent figures from the national Until Labour Cost Survey, for example, showed Kingston Hospital to be among the 1% most efficient units in the country.*'

The negative aspect of this lean performance was that the hospital had little scope to absorb cost pressures, such as increased emergency admissions. The Trust had achieved its financial targets in seven out of eight financial years 1991/2 to 1998/9[26] (in spite of an underlying operating deficit of £1m[27]) but by 1996/97 the hospital was submitting a frankly pessimistic business plan. It projected a deficit of nearly £2m which it hoped to bridge by selling the staff residences (in a sale and lease-back arrangement). The staff residences represented the last piece of capital available for release and thereafter the Trust would be fully exposed to its growing recurrent deficit.

11.3 1991-92 : Competitive Ethos in the Early Days of the Market

As a first wave Trust Kingston Hospital adopted an energetic approach to the internal market and was considered to be aggressive and somewhat predatory. This has an impact later in the

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[26] 1993/94 was the exception to this.

[27] Noted in 1996/97 Business Plan.

chronology when Kingston's perceived strength proves to be a negative image and a drawback to merging with Queen Mary's.

11.3.1 Marketing Spare Capacity to GP Fundholders

Like other Trusts at the time Kingston Hospital was trying to attract patients from GP Fundholders (GPFH) which represented the fluid element of the internal market where funding followed the patient. Extracts from a Trust Board paper[28] illustrate how the Trust viewed the market and GP Fundholders in the earlier days of the reforms:

As a hospital we need to be alert to GP Fundholders as these represent the volatile element of the internal market. We need to draw in almost £700,000 (estimated at 700 cases) just to stand still. GP Fundholders will switch loyalties between different hospitals within a reasonable geographical radius, probably equivalent to 45 mins - 1 hour in travel time. ... GP Fundholders from these areas have already expressed interest in testing out Kingston's services as the hospital has a reputation for efficiency and innovation. The marketing exercise has already been done to a certain extent - all GPFH practices have received copies of our tariff and newsletters containing waiting times and they were each approached individually at the beginning of the year.

Now that their interest has been stimulated we need to meet their expectations, and this can best be done by identifying their patients on the waiting list and scheduling them at the earliest available date (taking into account clinical urgency and other contractual commitments). If we respond promptly to GPFH's referrals then we will (a) succeed in securing the £700k which is already built into the budget, and (b) draw in additional referrals. If a GPFH has a sufficiently large number of patients waiting then we can reserve spare capacity and treat them as special waiting list initiatives.

11.3.2 Competition on Epsom's territory

The Old Cottage Hospital had been closed by Mid Surrey Health Authority prior to Trust status. An Epsom-based practice was part of the first wave of GP Fundholders and achieved national recognition for its entrepreneurial approach by buying the Cottage Hospital with plans to develop it into an outpatient and minor surgery facility, converting the premises back to its original function as a community hospital but this time run by GPs. The practice entered talks with Kingston Hospital to develop the service jointly using consultants from Kingston Hospital. This was launched as a new service upon Epsom's patch which provided additional income to Kingston Trust at Epsom's expense.

Epsom retaliated by placing consultants in Surbiton Hospital which is the community hospital local to Kingston and managed by Kingston & Esher community unit. Both Trusts

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28 *Marketing Spare Capacity*, Paper to Trust Board Meeting 27.5.92

had in effect shifted the boundaries of their catchment population and traded market share. The Cottage Hospital initiative became increasingly unpopular with surgeons at Kingston Hospital since they were obliged to conduct these 'outreach' sessions personally and see perhaps 12 patients, most of whom would have routine problems. Their hospital-based services, by contrast, were run with the assistance of junior doctors who dealt with much of the routine work. Up to 60 patients could pass through a single session at Kingston, enabling the consultants to concentrate on the more complex or interesting cases. A further irritation was fuelled, as one consultant put it, by the fact that 'there were no kick backs' from the Cottage Hospital, i.e. no private patient referrals. The initiative remained controversial.

11.3.3 Kingston Hospital Proposes a Merger with Kingston & Esher Community Unit

Discussions were held in July 1992 between the acute Trust and the community unit (still directly managed) on the possibility of a merger. The community unit opposed it, not least because it considered it a marriage of '*unequal partners - Kingston Hospital viewed as predator*'[29]. The proposal to merge the acute and community service was rejected, leaving Kingston Hospital strategically vulnerable as an acute hospital with no community hospitals. Any strategy to transfer resources from secondary acute care to community-based services would threaten Kingston Hospital, acting as a future disincentive to transferring services between secondary, community and primary care.

11.4 1993: Market Structure and the Case for Closure of Queen Mary's

Kingston Hospital sits on the outer London and Surrey border. It is not sufficiently central to have been included in the Tomlinson review of London's Health Service (Tomlinson, 1992) which concentrated on inner London's problem of many hospital sites over a small geographical area. It nevertheless shares similar problems which can be characterised as too many hospitals facing cost pressures and jostling for increasing shares in a cash-limited fund. The Department of Health put the spotlight on the south west London health economy in the response to Tomlinson presented by the then Secretary of State, Virginia Bottomley (Department of Health, 1993a):

> *In south west London, St George's role may be affected by the outcome of any Guy's/St Thomas' site appraisal. The services provided at St George's also need to be considered in conjunction with those at Queen Mary's Roehampton, Kingston and St Helier Hospitals. We have asked LIG [London Implementation Group], in cooperation with South West Thames RHA, to report further on likely developments in this sector in the autumn.* (paragraph 76)

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29 Source: *Position Paper on Business Planning & Contracting Function*, 14th July 1992, Kingston Community Unit and Kingston Hospital Trust

Following the Secretary of State's directive a review of acute services was undertaken for south west London. The review, chaired by the Chief Executive of Kingston & Esher Health Authority (now Kingston & Richmond Health Authority), considered the viability of Kingston, Queen Mary's Roehampton, St Helier and St George's. The Review recommended the closure of accident and emergency services on the Queen Mary's site and reprovision of inpatient services elsewhere, mainly to Kingston. The review stated that four hospitals needed to reduce to three and, in the longer term, possibly to two, (throwing into question the viability of St Helier which ultimately merged with Epsom Hospital on 1st April 1999). Following hostile reaction to the public consultation - stimulated by a high profile survival campaign orchestrated by Queen Mary's (including hands around the hospital and candlelight vigils) - the Regional Health Authority refused to recommend the findings to the Secretary of State. In short, the proposals were too contentious and were not accepted. Providers were then urged to find a solution which was acceptable to both. South Thames Region distanced itself from the decision making process and the onus fell to the Trusts to sort something out. The general view was that the case for change was too overtly driven by a search for financial savings. This was unacceptable to the public and hence with politicians, so that a revised proposal based on clinical grounds was sought as an alternative.

11.5 1994-96: New Strategy

The management drive to close Queen Mary's Hospital on financial grounds had failed. The resource pressures continued to exist, however, and health authorities in south west London were forced to continue to look for savings by rationalising services. Kingston & Richmond Health Authority and Merton, Sutton and Wandsworth Health Authority were overspent by £13 million recurrently[30] on services to a local population which received 95% of its treatment from 9 hospitals (Kingston, Queen Mary's Roehampton, Charing Cross, Chelsea & Westminster, St Thomas', West Middlesex, St George's, St Helier, Epsom[31]), thus representing an excess of capacity over funding. Although the local health economy was weak, with Health Authority deficits of over £10m, the immediate force for real change proved to be clinical through threatened withdrawal of training recognition for junior doctors' posts. The catalyst was a critical report by the Standards Advisory Committee of the Royal College of Surgeons on training in Kingston and Queen Mary's. To maintain an emergency service the two hospitals were forced to work together, in effect by merging their junior doctor rotas by a given deadline, or lose their ability to employ junior medical staff.

The clinical drive for change came from a combination of Calman and Junior Doctors' New Deal requirements which affected general surgery and orthopaedics. These specialties need larger numbers of consultants to survive, forcing the consultants themselves to search for a

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30 *Proposals for Changes in Services at Kingston Hospital and Queen Mary's Hospital Roehampton* - Public Consultation Document presented by Kingston & Richmond and Merton Sutton & Wandsworth Health Authorities, September 1996, page 7

31 Ibid

solution by pooling their resources. This stimulated a second review which was ultimately brought to a successful conclusion in 1996. Its aims were[32] :

- *the provision of clinically safe and effective services in the immediate and long term which will better meet the health needs of the local population;*
- *the provision of viable services on both hospital sites - Kingston and Queen Mary's Hospital Roehampton - building on the particular strengths of each;*
- *services that are affordable within the money likely to be available to the Health Authorities.*

The review resulted in a shift of inpatient services in paediatrics, obstetrics and gynaecology to Kingston and transfer of emergency in-patient surgery to Kingston from 1st April 1997. The chronology of events leading to this highlights the influence of medical staff and the importance of clinical opinion in influencing events. It also illustrates the protectiveness of local communities towards their local hospital and how politicians need to respond to this, emphasising the strong political dynamic within the internal market structure.

11.5.1 Chronology

In March 1994 an orthopaedic consultant at Queen Mary's Hospital tried to rationalise orthopaedic services in the area. The Postgraduate Dean wrote congratulating him saying that he believed the scheme was meeting opposition from Chief Executives of the Trusts. The Kingston Hospital CEO responded to the consultant challenging his planning assumptions (beds, length of stay, funding, day case proportions), while not objecting to the principle of the proposals. The Local Medical Committee (LMC) did not support the proposal although encouragement was received from Brian Mawhinney MP, Tom Sackville MP, the Regional Director and the CEO of Queen Mary's Hospital. The Regional Health Authority was pleased that a collaborative approach was being taken: '*There is clearly both the need and the opportunity for some radical developments in SW London and it would be preferable if this could be achieved through collaboration between purchasers and providers rather than external direction.*' A statement from the London Implementation Group (LIG) in April 1994 said that the Secretary of State would not be giving direction; it is a local matter.

In May 1994 the Chief Executives of five south west London providers met in a forum which represented Kingston Hospital, St George's, Mayday, Epsom, Richmond Twickenham and Roehampton (RTR), and St Helier. At the same time a purchaser initiative was launched when the Chief Executive of Merton, Sutton & Wandsworth Health Authority proposed meetings to develop new models of care for the future, in the knowledge that recurrent funding could not sustain existing service patterns into the future. The first service to be tested in this way was urology. The weakness in the urology review lay in establishing a case for change since the financial dilemma pointed to problems but no obvious solution and there

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[32] Ibid

was no consensus among clinicians on the best way forward. The urology review demonstrated that no case could be regarded as robust if it did not have backing from the consultants involved. It also showed how difficult it would be to reconfigure services on a specialty by specialty basis.

In February 1995 Queen Mary's proposed a new development on its site known as the Rapid Diagnostic Centre, which would provide a modern diagnostic facility enabling patients to receive a same-day results and diagnostic service. The prospect of new capital investment on a site which was under pressure to close was not well received by Kingston Hospital Trust. The scheme was dependent upon being a co-operative venture with Kingston Hospital but the Trust did not support it as it appeared to be a whole hospital development of an acute site which was expected to close. The idea was never fully dispelled and three years later, in March 1998, Alan Milburn, Labour minister for health, wrote to the CHC assuring it that a high level Rapid Diagnostic Centre would be built and that he expected Health Authorities to show commitment and move quickly on it. This was a political response to the CHC's objection to moving services off the Queen Mary's site.

In July 1995 a Joint Strategy Group was established, led by Kingston & Richmond Health Authority, and its first meeting took place 7.7.95 attended by GPs, Merton, Sutton & Wandsworth Health Authority, Kingston & Richmond Health Authority, Kingston Hospital Trust and RTR Trust. The strategy was to be bound by the following constraints:

- an accident and emergency (A&E) department to remain on both sites;
- cost savings of £600,000 to be realised by each Trust;
- a directive to both Trusts to examine the feasibility of providing services jointly.

The financial constraint formed part of the Health Authority's agenda to meet funding targets, but it conflicted with the instruction to ensure that accident and emergency services continued to be provided on both Kingston and Queen Mary's sites. This condition was a political rather than a clinical constraint, a legacy from the unsuccessful 1993 Review which had proposed closure of Queen Mary's A&E department and had ultimately been rejected. Kingston Hospital was sceptical that any savings could be made while there remained so little scope for rationalisation since A&E would need to be supported by the full range of medical and surgical specialties, thereby ensuring that full District General Hospital services would be retained on both sites.

The Kingston Hospital CEO wrote to business managers informing them that they were to be engaged in service reviews between Kingston and Queen Mary's during July-August 1995. This would involve joint meetings between managers and clinicians across departments and should provide information for the purchasing intentions by 15.9.95.

In October 1995 Kingston & Richmond Health Authority stated in its purchasing intentions that its strategy was to shift care from acute/secondary to the primary sector and that *'reconfiguration and development of local services will be actively promoted'*. Prior

approval would be needed, particularly from consultants, to service changes in Kingston Hospital/Queen Mary's.

In April 1996 the £600k savings sought for 1996/67 were not achieved and, instead, cost pressures led to increased unit costs and activity in local acute hospitals. Kingston & Richmond Health Authority therefore planned a deficit in 1996/97 and GP Fundholders accepted a reduction in the budget. The Regional Office insisted that a plan should be put in place to clear the deficit. A study to produce recommendations was proposed for mid July in advance of the September 1996 purchasing intentions to plan contract changes for 1997/978. The Kingston & Richmond Health Authority CEO wrote to Jeremy Hanley, local MP, on 12.4.96 inviting him to a meeting. As briefing he supplied a DHA paper 16.4.96 which summarised the position to date:

Kingston & Richmond Health Authority and GP Fundholders have encouraged collaboration between Queen Mary's and Kingston Hospitals. Over the last year collaborative arrangements have been developed in several clinical areas. The purpose is to (i) strengthen clinical services and (ii) reduce unit costs to release money for service developments. Pressures for change are clinical and economic and have increased sharply in recent months. A new study is therefore proposed with the aim of delivering tangible changes over the next 12 months.

The clinical reasons for change are linked to Calman and include:

(1) Training of junior doctors. Registrar posts in general surgery and anaesthetics have already been withdrawn from hospitals that cannot achieve accreditation. Early indications have been received that Kingston Hospital/Queen Mary's Hospital will lose accreditation;

(2) Cancer services - greater degree of specialisation in cancer treatment from April 1997;

(3) emergency hospital treatment - local pressures;

(4) pressure to develop specialist services, e.g. MRI.

Economic reasons for change include:

(1) The need to reduce unit costs;

(2) The need to find savings to respond to cost pressures, e.g. Beta-Interferon, Taxol, blood products;

(3) The need to release funds to develop primary care.

Mid July provided the next critical point and all subsequent events happened in the knowledge that a review decision would be forthcoming soon. This presented a specific threat to Queen Mary's which undertook its own independent study known as the 'Flind Review', led by the Trust's Chairman Christopher Flind.

The Health Authority issued a press release informing the public of a new impending review. This received adverse press comment and the CEO of Merton, Sutton and Wandsworth Health Authority wrote to Kingston Hospital's CEO on 22.4.96 that the press response had been substantial and misleading and suggested that they should meet to give a Press briefing.

In the meantime Kingston was having its own discussion with the Regional Office about its deepening financial problem with a predicted recurrent income and expenditure gap of £1.4 million. Kingston Hospital was asked in April 1996 to provide a 'contingency plan', to show the impact of standing alone on the basis that service mergers with Queen Mary's could happen slowly or not at all. This contingency plan was requested by a relatively junior officer at the Region and cut across the higher level review described in the 16.4.96 briefing paper above. Nevertheless, Kingston complied by setting out a contingency plan which demonstrated that it would be impossible to achieve financial balance and remain a viable DGH since this would require financial savings which would destabilise the service, summarised in the following extract:

> *'If Kingston Hospital stands alone it will need to find savings of £3m-£7m during the next two years. The Regional Office asked Kingston to develop a contingency plan to cope with this and show how, as a minimum, the Trust would deal with its recurrent deficit plus medical staff increases arising from Calman and the New Deal, i.e. £3m. This paper examines a comprehensive set of options and concludes that, to make savings on this scale, it will be necessary to remove large elements of the clinical service. Cost reductions would be led by closing beds:*
>
> - *50/60 beds closed to save £3m - bed closures would need to be accompanied by proportionate reductions in all clinical support departments as well as forcing a cut in Trust-wide overheads.*
> - *100 beds closed to save £7.3m - feasible only with slowing of emergency admissions. This could be effected by part-closure of A&E.*
>
> *District General Hospitals have a range of specialties which are balanced to provide medical training and experience as well as patient services. A change in the balance of specialties creates a domino effect in which recognition is withdrawn due to lack of experience in specific areas, e.g. cancer surgery, airways for anaesthetics, and renders the specialty unable to provide emergency cover.'*

The paper concluded that cuts on this scale (6.5% - 15.5% of expenditure) would make the hospital non-viable as a DGH service. The Regional Office did not pursue this line of reasoning further and was, in any case, overtaken by events associated with the separate Review process. The Kingston & Richmond Health Authority CEO wrote to Kingston Hospital's CEO 14.6.96 urging him to take no action on downsizing.

Higher level discussions were taking place at the regional and political level. William Wells (Regional Chairman) met David Mellor MP and Gerald Malone MP and minister for health

21.5.96 and wanted a briefing on progress from the CEOs of both Kingston and Queen Mary's Hospitals. Shortly after this the Director of the Regional Health Authority wrote to the four Health Authority/Trust Chief Executives 24.5.96 that he was sceptical about the affordability of proposed service solutions and asserted his authority by summoning a meeting on 29.5.96 at 4pm in Paddington. Clinical viability versus affordability was the key theme of the meeting and it produced a timetable of communication and agreement to defer appointment of a general surgeon at Queen Mary's. This cut across Queen Mary's desire to continue to fill vacant posts to retain the 'Putney market'.

In July 1996 a report was published which recommended the merging of surgical and orthopaedic departments between the two sites with a separation of elective and emergency work: emergency work would be conducted at Kingston while elective work would be undertaken at Queen Mary's. It recommended that these changes should take effect from 1st April 1997.

This document fed the consultation document which appeared in September 1996. However the split site arrangement was privately recognised as 'intermediate' and non-viable in the long term, a point made by the Regional Finance Director when the review results were disclosed in July 1996. South Thames Regional Director of Finance wrote to the Chief Executive of Merton, Sutton & Wandsworth Health Authority 9.7.96 that he was disappointed since the proposals put forward were clinically viable but not financially viable and were 'deemed unaffordable'. He urged the service to look at other configurations.

The Kingston & Richmond Health Authority CEO wrote to Health Authority and Trust Chief Executives 16.7.96 on the acceptability of options under three criteria: clinical, financial, political. He argued that there was a conflict between financial and political success although less of a conflict between financial and clinical viability. This conflict was made quite explicit in the letter which showed the following:

Figure 11.1: Acceptability of Options

	Clinical	Financial	Political
Option			
1. Status Quo	✖	✖	✖
Intermediate: General Surgery & Trauma & Orthopaedics Inpatients: emergency @ Kingston Hospital, elective @ Queen Mary's Gynae, obstetrics, paediatric inpatients at Kingston Hospital	✓	✖	✓
Long Term Configuration As for 'intermediate' with additional inpatient activity from Queen Mary's to Kingston Hospital: elective surgical and some acute medical	✓	✓	✖

Management consultants were engaged to begin a new phase of work. The Kingston & Richmond Health Authority CEO wrote 19.7.96 to a member of the team outlining 'alternatives' for consideration:

(1) *Consultant only service - emergency services on both sites (i.e. no training grade cover);*
(2) *Consultant plus staff grade only service;*
(3) *Reconfiguration of inpatient activity for the surgical specialties along the lines of Simpson Option 2 and the 'Flind Report'. This alternative would be recommended!*

Region promised to provide transitional funding if the four parties could present a united front.

Roy Galley (Chairman of Kingston & Richmond Health Authority) wrote to Toby Jessell, MP, that the message about Queen Mary's and Kingston could be summarised according to three themes: (i) increasing specialisation; (ii) Calman training; (iii) neither Queen Mary's nor Kingston Hospital alone has sufficient consultants to justify the number of higher trained surgical trainees needed for 24 hour cover.

CEOs of the two health authorities (Kingston & Richmond and Merton, Sutton & Wandsworth) wrote to Queen Mary's Hospital CEO 15.8.96 about shifting inpatient work relating to paediatrics, gynaecology and obstetrics from Queen Mary's as a *'clinical necessity and we will be forced to signal change in our purchasing intentions.'* An extract from the Multifund Purchasing Intentions September 1996 showed that they wanted to purchase Kingston Hospital/Queen Mary's joint services based on one administration, one price list and one service.

In September 1996 Health Authorities tried to add their pressure after the CEO of Kingston Hospital wrote to the Kingston & Richmond Health Authority CEO 20.9.96 suggesting that managers at Queen Mary's had been *'instructed not to liaise or communicate with their colleagues at Kingston Hospital'*. The CEO of Merton, Sutton & Wandsworth Health Authority wrote to the two hospital CEOs 23.9.96: *'Individual clinicians appear, at the present time, to be pursuing different options and this is causing great confusion for everybody, which does not bode well for the success of joint departments as envisaged in the consultation document'*. He added that the Health Authority needed to feel confident if it were to purchase services from either hospital.

In October 1996 10 public meetings were held 14th October - 26th November 1996 to consult on the review recommendations. The Royal College of Nurses responded that '*change is inevitable*'. The GP view was expressed through Kingston & Richmond Multifund Press Release 15.10.96, *"Doctors call for Hospital Merger"*, in which GPs unanimously agreed that merger of management of Queen Mary's/Kingston Hospital was essential to maintaining viability of both hospital sites. The Health Authority CEO (Kingston

& Richmond) wrote to the Finance Director at the Region putting forward the GP views about a merged management. The Local Medical Committee (LMC) wrote to Kingston Hospital's CEO 22.10.96 that it would support full merger under management of a single Trust; the GPs on the LMC were concerned at change which would compromise the acute medical service at Queen Mary's [i.e. suggesting that they want managerial overhead savings but not site cost savings through service transfers].

The proposals were accepted by the local population and the Secretary of State. This resulted in closure of the accident and emergency service at Queen Mary's Hospital from 1st April 1997. Inpatient gynaecology, paediatrics and obstetrics plus emergency surgery was transferred to Kingston 1.4.97 and elective surgery was transferred to Queen Mary's 1.4.97.

After this surgical reorganisation a further review tackling medical services was undertaken. A senior health authority source noted that *'it had to take place after the election and it was to be clinically led.'* The work concluded in a final transfer of inpatients services from Queen Mary's, mainly to Kingston, scheduled for 4th August 1998.

Ministers emphasised throughout the consultation process that Queen Mary's had a strong future as a local community hospital. The Rapid Diagnostic Centre (RDC), combining outpatient services with pathology and other investigative services to allow a 'one stop' service to local patients, gained increasing prominence as a means of developing new local services on the site. A survey by Finnamore Consultants found that GPs in the Roehampton area were very supportive of this idea while GPs in the Kingston area felt that it would be an unnecessary duplication and dilution of resources and that the money would be more effectively used by investing it on the Kingston site. The RDC was given ministerial support in March 1998[33] in the parliamentary response to Merton, Sutton & Wandsworth Community Health Council's objection to the Health Authority proposals. The service transfer was therefore approved by the Secretary of State but with conditions attached.

11.6 Queen Mary's Fight for Survival

RTR Trust orchestrated a long and determined battle for Queen Mary's in a 'Save our Hospital' campaign. Its aim was clearly survival and is central to the question 'What Motivates Trusts?'. Its behaviour was perceived as being very different from that of Kingston Hospital although it could be argued that both Trusts were pursuing a survival strategy but from positions of different strength, using different methods and with different degrees of success. Queen Mary's ultimately lost its role as an acute hospital and most of the services were transferred to Kingston. The quotations in the chronology which follows illustrate the passionate and emotive defence of the hospital which met disapproval from policy makers. The tide of opinion at Queen Mary's Hospital turned after it commissioned

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[33] by Alan Milburn, MP, and minister for health to the Chairman of Merton, Sutton & Wandsworth Community Health Council, March 1998

an independent study of its own which concluded that Queen Mary's was not viable as a District General Hospital. As a health authority executive remarked: '*This clinched it for Queen Mary's consultants. This was overwhelming evidence from an internally commissioned study. A tortuous process'*. The chronology section illustrates Queen Mary's approach, described as a *'bunker mentality'*, and the role of politicians as perceived by people outside the Trust.

11.6.1 Chronology

In June 1996 Christopher Flind, Chairman of RTR Trust, published a review of Queen Mary's future (undertaken independently of the Health Authority) in which he proposed that Queen Mary's University Hospital should be specialist and local. He conceded that inpatient ENT, urology, paediatrics and gynaecology should be moved elsewhere and proposed that links should be developed with St George's (teaching) Hospital. The review made it clear that Queen Mary's University Hospital saw its future with a teaching hospital rather than through links with a District General Hospital, revealing a distaste for collaboration with Kingston. Christopher Flind stated that elective surgery would be conducted on site and a new hospital would be developed on 7 acres. The local press handling was noted by a manager at Kingston: *'Flind announced a new hospital to be built on Queen Mary's Hospital site at £43 million. The Local Authority was present and said planning permission OK. Lorraine's deadline* [local Informer journalist] *was yesterday lunchtime and she has reported this wonderful news! She didn't seem to realise that this was Flindspeak and that an independent report was due in 2 weeks."*

David Mellor (Conservative MP for Putney, a marginal seat, which covered Queen Mary's Hospital) was very vocal in his support for the hospital. A senior figure acknowledged the dynamics: '*Politicians play a role. Christopher Flind (Chairman of RTR Trust) is very close to David Mellor. Mrs Flind is Chairman of the Conservative Association. David Mellor - he owes them one*[34]*. RTR Health Authority was drawn with strange boundaries - it was drawn with politicians in mind in order to preserve Queen Mary's Hospital. Queen Mary's is assured that the politicians are behind them.'* At the same time a Conservative party source close to David Mellor who worked in Kingston Hospital believed that the MP was really working to their agenda: '*The politicians won't stand in the way of the Queen Mary/Kingston merger. I've sorted a political deal. It's sorted. That's where I've been this morning - explaining the impact of the market to local MPs. But no-one in the management structure has the guts to make a decision.'* The public face of events suggest that this unspecified merger 'deal' was not secure and a parliamentary colleague of Mr Mellor was clear in his view that the impending general election added an extra urgency and instability to the battle ground: *'It's become excessively highly charged at the Queen Mary's end of it. All the politicians in Wandsworth, whether David Mellor or the Labour parliamentary candidate for Putney, they are vying one against the other about who can fight the best battle. With an*

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[34] following local constituency support in the aftermath of the Victoria de Sanchas affair

election looming the idea of the Conservative MP and the Labour candidate vying for who can fight best for Roehampton is quite important. They are arguing from a rather emotive position.' Mr Mellor used his column *'View from Westminster'* in *Wandsworth Borough News* to launch personal and scathing attacks on the Chief Executive of Kingston & Richmond Health Authority, which his parliamentary colleagues disapproved of as *'quite unjustified. I don't think it's the business of MPs to be writing that sort of comment in a newspaper piece.'*

In September 1996 Stephen Dorrell (Secretary of State for Health) wrote to David Mellor: *'I can confirm that we are continuing to plan on the basis that hospital provision on the Roehampton site will form an important part of services for local residents, whatever the conclusion of the current processes, although the exact configuration of services will naturally evolve and change over the years to reflect changes in patterns of treatment and local demand.'* Queen Mary's seized on this statement by issuing a press release 25.9.96 ***'Secretary of State for Health gives his assurances about the future of Queen Mary's University Hospital'.*** *'Yet again, the purveyors of doom and gloom have been confounded. Let us hope that Queen Mary's can now be allowed to get on with its job of treating the sick without continuing threat and rumour.'*

Later on in the process (October 1996) Queen Mary's held its Annual General Meeting in which the Trust's Board was seen by observers to be publicly supporting the consultation document while undermining public confidence in the loss of the accident and emergency department and, hence, District General Hospital status: *'If you have a major car accident with broken bones, you will not be brought to Queen Mary's'; 'unless your family doctor is absolutely sure of what's the matter with you, you won't be able to go to Queen Mary's'.* During the public meeting Christopher Flind addressed a packed audience: *'We need your active support. The threat which hangs over our hospital is complex... We need extra people to write letters to Health Authorities..'* David Mellor stated *'there is nothing I personally will not do in order to maintain a quality hospital on this site. If we all go forward with this conviction - forget about party politics.'* The Queen Mary's Local Support Group Report reported on the AGM that *'Christopher Flind and John Dennis told the meeting that the Trust was facing an extremely serious situation .... to lose £10m.'*

The Chief Executive of Kingston & Richmond, Chairman of Kingston & Richmond and the sitting local MP were each interviewed and discussed the aims of Queen Mary's in relation to Kingston Hospital.

> *'The aims of the hospitals (Queen Mary's and Kingston) are not exactly the same. The Boards are pursuing something different. RTR is aiming for survival as an organisation. We need a merger/demerger. Some Trusts are less willing to contemplate that. RTR is unwilling. Kingston Hospital and Kingston & District Community - they wouldn't mind being disbanded and put back. I think the Boards have different objectives from each other. RTR is seeking its own preservation, i.e.*

Queen Mary's Hospital. They behave as if they want to preserve themselves as a Board or an organisation. RTR has got into the habit of protection. If they had a different attitude the dynamics would be different. Kingston Hospital is realistic - it sees no future as an independent hospital.'

It was recognised that the Trust Board and the clinicians within Queen Mary's were not necessarily working to the same ends: '*There are quite a lot of consultants at Queen Mary's who are very helpful and supportive. (Not all of them.) That puts them in a difficult position because they are being managed by a Board which has a different view from the clinicians.'*

11.7 Medical Staffing as the Key Driver for Change

The intransigence and hostility of RTR Trust's Board to change was clear to all observers. Nevertheless it has been noted here that the review process was ultimately successful in achieving service change. The key to this success lay in the consultant body and their recognition that clinical services would fail unless the two hospitals merged their services. The issue turned on medical education and the recognition needed to train junior doctors. Royal Colleges are the guardians of medical and dental education and they have the power to withdraw training recognition, rendering hospitals unable to employ the junior doctors needed to cover on-call rotas (i.e. out of hours emergency cover) and thus unable to provide the emergency service needed to function as a district general hospital.

In June 1996 the Chairmen of Kingston & Richmond and Merton Sutton & Wandsworth Health Authorities wrote to Christopher Flind 28.6.96 spelling out their concern about general surgery and the lack of intention to merge services with Kingston Hospital *'We hope that you can appreciate that this outcome would be unacceptable because it would leave the population of Kingston & Richmond without a viable DGH service'.*

In July 1996 the Clinical Tutor of General Surgery at Kingston Hospital applied to the Deanery in Post Graduate Medical and Dental Education to gain approval for a locum specialist registrar post for a grace period. Without this approval the general surgical service would fold since both Queen Mary's and Kingston Hospital were scheduled to lose recognition of registrar posts from October 1996 due to failure to meet junior doctors' hours requirements. He received a letter 29.7.96 from the Joint Committee on Higher Surgical Training agreeing to extend the period of recognition to 31.3.97.

In September 1996 a meeting took place between consultant surgeons from Queen Mary's, Welwyn, Hillingdon, Chelsea & Westminster, Kingston Hospital, Royal Marsden & Watford to discuss trainee attachments. This followed the very critical SAC (Royal College Standards Advisory Committee) report after a visit to Queen Mary's and Kingston Hospital suggesting that both North Thames and South Thames should pull out their trainees from these hospitals. The view of Kingston Hospital and Queen Mary's was that *'the most likely development was*

for the surgical service at Roehampton to be assimilated into Kingston. The rate of this progress was hard to predict but there would be an interim period when elective surgery was undertaken at Roehampton and non-elective work at Kingston Hospital.'

Progress on joining clinical services on trauma & orthopaedics continued (letter 25.9.96 from Kingston Hospital's CEO to the Trust Medical Director) but problems emerged and a consultant general surgeon at Kingston wrote to the CEO that he was very concerned that Queen Mary's was still talking to St George's. A series of meetings followed.

The importance of clinicians to the process was highlighted in a letter from Kingston & Richmond's CEO to a consultant at Kingston Hospital, on how to merge a department. He set out four stages: (i) refer the matter to the two Trust chief executives, (ii) bring together clinicians and managers from Queen Mary's and Kingston Hospitals in a series of discussions, (iii) agree, (iv) then bring into the discussions health authorities, GPs, and medical schools. A senior figure in the Health Authority commented in interview: '*Doctors are very important. This time it is the clinical argument which is leading - they are strong arguments. And the GPs say the hospitals should merge. Among the consultants there is mixed support - some consultants are not keen.*' It was acknowledged that clinicians were pivotal to securing agreement: *'If clinicians feel that it makes clinical sense then that will drive it. If doctors feel it is not safe to practice then that will mobilise GPs. I would prefer consultants to influence GPs and then for the Health Authority to publicise it.'*

11.8 1997-1998 : Leading to the Current Position

Clinical departments have now merged, thus producing the necessary changes to sustain a viable clinical service. Kingston Hospital and Richmond, Twickenham & Roehampton Trusts continue to operate as separate Trusts with separate management boards. The Queen Mary's site remains open as a hospital but does not have a district general hospital function. It belongs to the RTR Trust (subsequently restructured to become the South West London Community NHS Trust) even though clinical outpatient services are provided there by Kingston Hospital Trust, setting an agenda of potential conflict for the future. The key issue now exercising the minds of Health Authority and Trust managers is the poor financial state left by the merger. At this stage it would be fair to suggest that clinical service aims have been achieved but the management financial agenda is in a state of disarray. The chronology of events from April 1997 onwards is charted below.

11.8.1 Chronology

In April 1997 an interim Chief Executive appointment was made at Queen Mary's and a permanent Chief Executive was later appointed to head the RTR Trust from May 1998. A senior figure within Kingston Hospital summed up the situation prior to the April transfer of services. '*Kingston Hospital is seen as the dominant party. This is a disadvantage. Changes are to take place from 1st April 1997 - it is very hard to be certain what will*

happen. Queen Mary's is being difficult. Their CEO resigned the day after the Health Authority announcement was made. A new Chief Executive is being appointed for two years. We shouldn't do it. We should just merge from April.'

A consultancy group, Finnamores, had been commissioned to undertake financial analysis as part of the review process. It projected a net saving of £9m revenue to be achieved by decanting remaining acute inpatient services from Queen Mary's, selling Putney Hospital, and allowing patients to flow naturally to an alternative hospital. It projected that Kingston would take 70%-80% of work, with some going to Chelsea & Westminster, St George's and Charing Cross. Kingston & Richmond Health Authority made it clear in the strategy document published in November 1997 that £9m net saving to the three health authorities (Kingston & Richmond, Merton Sutton & Wandsworth and Ealing, Hammersmith & Hounslow) would be the minimum needed and that, due to capitation problems, further savings would be needed in the future.

At the beginning of the financial year, in March 1997, a senior Kingston Hospital manager described how a £4m deficit had been brought down to £750k by a combination of cost saving measures and cash injection: *'Central departments are to lose 10% and clinical departments are to lose 1%. The purchasers coughed up. Kingston & Richmond put up £2.9m, taken largely from Queen Mary's. But there is a rumour (via the Estates Department) that Queen Mary's spent £1m on roof repairs to get rid of surplus cash. You can never know the truth of these things.'*

In June 1998 the £9m projected savings were to comprise over 60% site costs which would only be realised when a satellite site, Putney Hospital, closed and services were consolidated on Queen Mary's. In other words, there was no timescale attached to it. In the meantime Queen Mary's continued to generate an ever-increasing deficit. It was estimated as £1.6m by March 1998, then rose to a rumoured £4.4m by June 1998[35]. Since there existed £6m of transitional (non-recurrent) funding injected by Region into the local health economy, this pointed to a recurrent deficit of £10.4m, enough to eliminate any future savings from the Queen Mary's changes. In the meantime, Kingston Hospital and other Trusts distanced themselves from the Finnamore projections[36]. Finance Directors were feeling beleaguered.

Inpatient services from August 1998 are being accommodated in the short term at Kingston by a 'temporary' ward block of 132 beds which, although firmly bolted into the ground and clad around a steel frame, has received only 5 years planning permission by the Royal Borough of Kingston and so needs to be replaced by a permanent structure by the year 2002. The anticipated permanent structure at Kingston is known as 'Phase 5' and is being planned

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[35] Acute Strategy Group Meeting, Kingston & Richmond Health Authority, 16th June 1998

[36] They estimated that the work transfer to Kingston Hospital would cost £20m to reprovide rather than £16m as originally projected. The original value of the work being transferred from Queen Mary's to Kingston was £19m, suggesting that the shift would result in a net increase of £1m rather than an immediate saving of £3m .

by the Trust with potential for extra bed capacity, on the basis that factors such as neighbouring Trust mergers, consolidation of accident and emergency services on a single site and withdrawal of medical staffing accreditation could expand the flow of patients to Kingston Hospital. One of the hospitals likely to be affected would be Epsom Hospital, harking back to the early days of the market and rivalry between the two Trusts. In the meantime, a press release announced that Epsom Hospital and St Helier are to engage in talks to produce a Trust merger from 1st April 1999. This is a different model of action from the Kingston Hospital/Queen Mary's transaction where services merged but the Trusts did not. In the case of St Helier/Epsom a new Trust, i.e. managerial merger, will precede any service reconfiguration.

A snapshot at August 1998 showed the financial situation to be a shambles. The previous estimate of £9 million savings projected by management consultants, Finnamore, had been recalculated as a projected cost increase of £10.4 million. The local health economy was already being supported by £6 million transitional funding from the Region and the Trusts agreed a further deficit budget of £4.6 million with the Regional Office. This implied a recurrent deficit of £21 million in 1999/00. The Regional Office was alarmed and warned the Kingston & Richmond Health Authority CEO that *'There is now a very real threat that the steering group will fail to deliver a viable plan'.* The Health Authority CEO felt aggrieved and replied '*You will appreciate that ... I feel frustrated in being held to account by you for the overall financial performance of this reconfiguration without any matching control over the Trusts' behaviour. Moreover, I feel particularly frustrated about the problems arising from the inadequacy of the RTR financial information. .... What I cannot accept responsibility for, and do not have the power to resolve, is the management of the release of overhead and estates costs from RTR.'* He concluded that the RTR Trust was insolvent and could not continue to operate without a substantial subsidy. He urged the regional office to turn the RTR Trust to a form of receivership by requiring the Trust '*to operate in a mode akin to receivership but working in partnership with the receiving Trusts'.* In terms of control, the Health Authority insisted that the main levers for dealing with RTR's costs lay with the Regional Office: *'We do not have levers of control. You do.'*

Further correspondence was directed to Chief Executives of the Trusts insisting that they should exert greater control over costs. The underlying problem appeared to be that insufficient resources were being pulled from Queen Mary's to sustain the new services at Kingston. Logically, this must be a consequence of either protectionism by RTR Trust who were holding back resources, an overstatement by Kingston concerning the resources needed, or an indication that the RTR service over the previous year had been running a low cost service due to high vacancies and a poor quality of service. RTR's ability throughout the process to obfuscate and withhold information means that the Health Authorities and other Trusts have had limited leverage with which to grasp this problem. Region, which might be expected to hold the ring, could exert pressure but not control and perceived it as a local issue.

The financial objective of the acute strategy had been to eliminate the underlying deficit, much of which was located at Queen Mary's. As the business plan for 1999/2000 at Kingston Hospital was being drafted it became apparent that the impact of the merger had been to shift the Queen Mary deficit to Kingston without any compensatory changes.

11.9 1999: Service Developments

In August 1998 the radiology department in Kingston Hospital submitted a proposal to the Trust Board to invest in a Magnetic Resonance Imaging scanner, attempting to make the case for this service development on the basis of funding. It was argued that the volume of patients referred to the neighbouring Atkinson Morley Hospital (2 miles away) was sufficiently high to warrant a scanner on site since the costs charged by AMH were equivalent to the cost of running the same level of activity on the Kingston site. The case was rejected on the basis of risk since it was anticipated that a scanner on site would stimulate demand for the service, raising utilisation and with it costs.

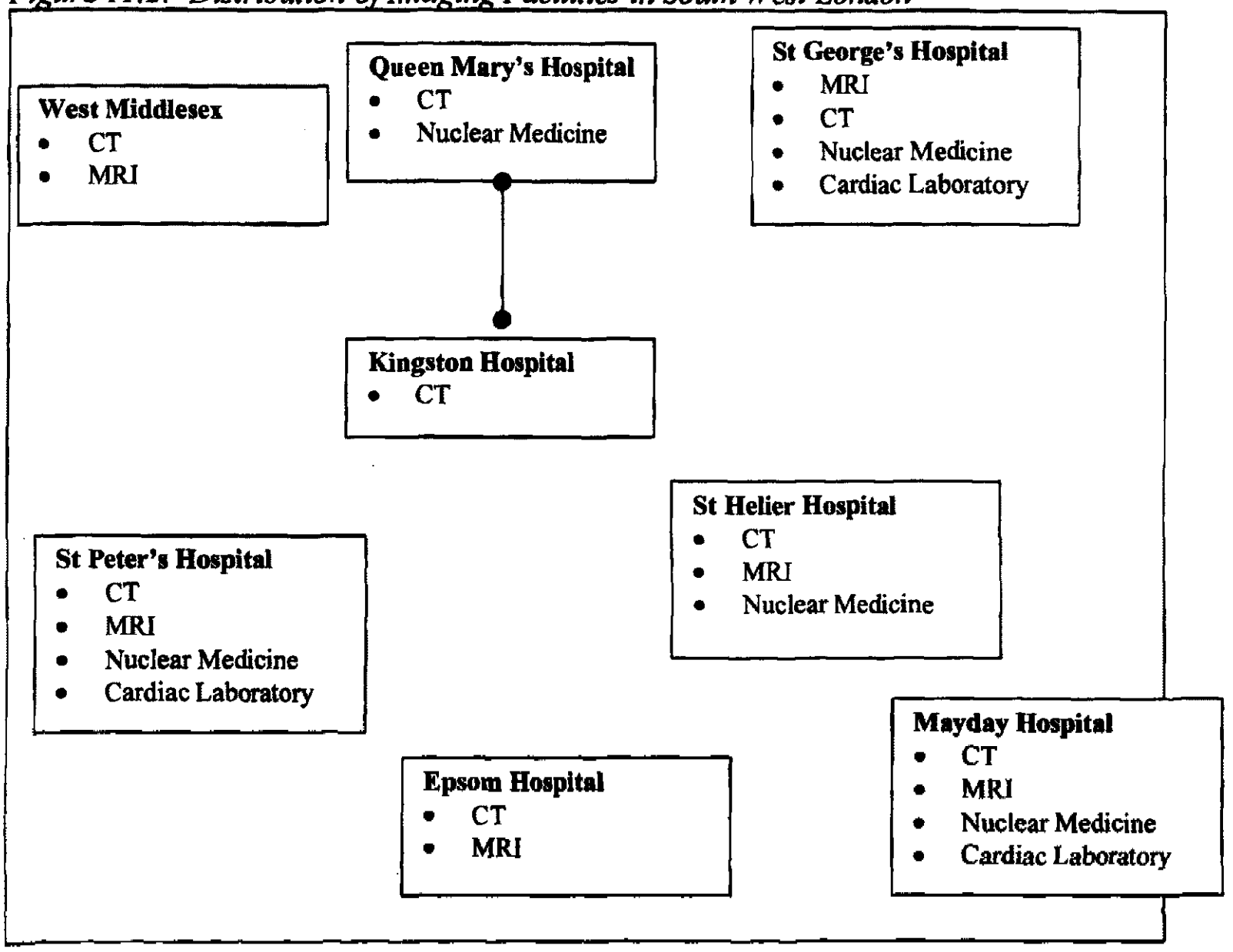
In September 1999 the case was resubmitted, this time on the basis of service quality. It was argued that every other hospital in the vicinity had an MRI scanner and that Kingston Hospital would be perceived as a second rate hospital over time. It would become impossible to recruit high calibre consultant radiologists and the hospital would be weakened strategically:

The distribution of imaging services in south west London reflects the status of MRI as a district general hospital facility. Kingston Hospital is unique, within a 45 minute travel radius, in failing to provide MRI as part of its radiology service. Consultants within radiology and other specialties have expressed concerns about the clinical standard of a radiology service which is not capable of providing ready access to MRI to both in-patients and outpatients. It is felt that an up-to-date and high quality service needs to provide MRI as a standard modality along with other radiological examinations. ..... A further driver of service quality is the clinical reputation of an acute hospital. This is inevitably influenced by the range of services provided and, in the case of radiology, depends on availability of MRI. Kingston Hospital's ability to attract high calibre recruits to consultant staffing in this specialty will depend in large measure on the Trust's range of services in relation to its neighbours.

The Figure below shows hospitals within a five mile radius to the north of Kingston (beyond which the concentration of hospitals increases in the inner London area, e.g. with proximity of Charing Cross, Hammersmith, Ealing, Chelsea and Westminster, St Thomas's, Guys and so on) and 10 miles to the south. Apart from the Queen Mary's/Kingston axis, every hospital has an MRI scanner. At the beginning of the internal market period only St George's (which owns Atkinson Morley Hospital) possessed an MRI scanner.

The economic case was made on the basis of risk-sharing with a private sector partner which would market spare capacity to other consumers. Kingston Hospital Board approved the strategic case to procure an MRI scanner and verbal approval was also received from the London Region NHS Executive.

Figure 11.2: Distribution of Imaging Facilities in South West London



11.9.1 Record of Key Decisions

(1) Secretary of State prompts review of SW London Acute Services in 'Making London Better, February 1993, her response to the Tomlinson Enquiry.

(2) SW London Review presented in Autumn 1993 recommended closure of Queen Mary's as an acute hospital, with closure of the Accident & Emergency department.

(3) The review was rejected. It was perceived as being too financially driven and politically unacceptable.

(4) Queen Mary's wanted to keep the Accident & Emergency Department open and to continue functioning as a District General Hospital (DGH). A vigorous survival campaign engaged the support of the local MP who was defending a marginal seat in Putney.

(5) Clinical reviews 1994 - 1996 indicated that Queen Mary's was not viable as a DGH.
(6) Royal College of Surgeons insisted on a merger of services September 1996.
(7) Consultants at both hospitals agreed.
(8) A&E department at Queen Mary's closed 1st April 1997.
(9) All inpatient services transferred out of Queen Mary's, mainly to Kingston Hospital, by 4th August 1998.
(10) Minister for Health responded to pressure from the Merton, Sutton & Wandsworth Community Health Council by promising a redevelopment of the Queen Mary's site in the form of a Rapid Diagnostic Centre.
(11) Financial targets remain unmet. The merger has not produced anticipated savings in the short term. Financial balance in the future needs to be achieved alongside the capital redevelopment of the Queen Mary's site which is now a political imperative, described locally as a '*phoenix rising from the ashes*'.
(12) Kingston Hospital Trust Board supported the Strategic Outline Case and Outline Business Case for developing an Imaging Centre which includes a new Magnetic Resonance Imaging scanner.

11.10 Conclusion

The underlying theme of the Queen Mary's and Kingston case study is one of survival. RTR Trust Board wanted their organisation to survive, the consultants wanted their clinical practice to survive, and Kingston Hospital was also working towards a survival objective. Competition theory acknowledges that survival is the firm's ultimate aim and so the motivation rests on what behaviour is required to ensure that survival.

The case study shows a health economy under severe financial pressure and lends support to Hypothesis 4 in which cost pressures bring managers and doctors into conflict, with doctors achieving the greater degree of success. In spite of managerial pressure the Trust was still unable to balance the books and incurred a growing recurrent operational deficit. Ultimately the clinical service configuration changed and the deficit in the health economy has subsequently widened rather than diminished.

The Queen Mary's/Kingston case study of the competitive market environment highlights the political nature of change in the health service and how market exit can be hindered if it conflicts with the interests of local politicians.

The changes which were eventually effected were driven by Royal College medical training requirements, presenting a cast-iron case which won the support of consultants, GPs and the local community. The financial pressures in themselves were not sufficiently powerful to produce change in the first South West London Review (1993) and by themselves were acknowledged to be insufficient in the next wave of reviews. Change was negotiated with

the consultants and where they refused to form a consensus, as in the urology review, the case for change became insubstantial.

The element of the case study relating to Magnetic Resonance Imaging provides an example of how consultants will endeavour to pursue service developments with the aim of improving the quality of their service. This is also consistent with the need to establish a good reputation for the service and to attract new consultant recruits. In the Kingston example, financial arguments could not support the case for development since purchase of an MRI scanner would lead to higher service costs. Instead, it was necessary to establish a service case based on the issue of service quality to gain agreement in principle. Thereafter the economic case was based on how to meet this service demand most cost-effectively.

The case for providing MRI facilities in a market environment was strengthened by the fact that each of the neighbouring hospitals owned a scanner. In a centrally planned system this high level of capacity would weaken the case for capital development since capacity would be collective rather then Trust-specific. In summary, this aspect of the case study suggests that service quality is a more potent driver of change than finance and that competition between neighbouring hospitals stimulates investment in technology, inducing cost pressures.

The Chief Executive of Kingston and Richmond Health Authority perceived a clear distinction between clinical, financial and political priorities. He observed (Figure 11.1) that there would be a conflict between financial and political success in the effort to reconfigure services by moving acute hospital services from the Queen Mary's to the Kingston site. This was, nevertheless, considered to be the only financially viable solution so he took steps to ensure that it was followed through. He was also clear that this solution produced no conflict between financial and clinical viability, conscious that the earlier 1993 review had foundered by producing a solution that was financially viable but had no clinical support. The Chief Executive's analysis proved to be accurate since the consultation process met with acceptance of the clinical and financial case, but politicians ceded ground to make the plan more palatable. Specifically, Alan Milburn promised the CHC that Queen Mary's would be redeveloped. While this flies in the face of financial objectives, it demonstrates the superior strength of political over managerial pressures, inhibiting the closure of hospitals and further weakening the budgetary constraint of local health economies.

CHAPTER 12. CONCLUSIONS AND POLICY IMPLICATIONS

This thesis has explored the motivation and goals of Trusts which were set up under statutory instrument from 1st April 1991 by Margaret Thatcher's Conservative Government and which continue to have a role following the Labour Government's White Paper (Department of Health, 1997). The research question asked *'What are the objectives of Trusts? What is the extent of the constraints under which they operate?'*

In this final chapter the results of the empirical work are drawn together according to a framework which starts with the 'inner state of Trusts', then looks at how this drives the behaviour of Trusts as organisations and, finally, how feedback from the environment modifies the underlying motivation or 'inner state'. The literature review established that consultants and managers could be treated as the dominant coalition working within hospitals, although there was no consensus upon what motivated these groups, nor on which group would dominate, if either. The motivation and behaviour of Trusts, it is postulated here, is determined by the interaction of these groups, with feedback provided by what used to be called the internal market.

12.1 Hypotheses

The basic premise is that doctors and managers have different sets of objectives in accordance with their incentive structure and professional duties. The divergence in objectives is consistent with the self-interest of each group, which takes into account feelings of self-worth and financial and career goals. Self-interest on the part of doctors is also consistent with any altruistic motivation they may have towards their patients' welfare encapsulated by the Hippocratic ethos of the profession. Self-regulation on the part of the medical profession has allowed a confluence of personal and professional aims, aligning doctors' interests with those of the individual patient. The groups' respective objectives have been summarised as budgetary or financial regulation for managers and service goals for doctors. The thrust of the hypotheses is that doctors are interested in production while managers are interested in the 'bottom line' and that doctors will win in the long term

The central piece of empirical work used a questionnaire survey to ask the dominant power coalition about their own and other people's objectives. This approach acknowledged the existence of potentially opposing interests without prejudging the balance of power. The second empirical study took cost and volume data and reviewed the performance of Trusts, going some way to answer the question of which group dominated Trusts' behaviour through the organisations' success in meeting financial targets or achieving service growth. The third strand of empirical work used a case study to consider the behaviour of Trusts in the context of their external environment. It portrayed the political imperatives which operate within the NHS and compared the success of financial and clinical drivers in producing change.

Figure 12.1: Structure of Empirical Methods, Test Areas and Test Subjects

Empirical Method	Test Area	Testing
Questionnaire	Principal Actors	Perceptions/Inner State of the Organisation
Quantitative Study	Trust Performance	Organisational Behaviour
Case Study	Environment	External Relationships/Dynamic Feedback

12.2 'Inner State' of Trusts

Management theories attribute organisational control to managers through decision systems and allocation of resources, so that management objectives and organisational objectives become indistinguishable. This line of reasoning was deemed inappropriate to the NHS setting in which doctors make decisions accounting for up to 75% of revenue costs (Gray, 1991). A more satisfactory model treated organisations as the product of the actions and interactions of motivated people pursuing purposes of their own. The sociological 'action perspective' encouraged an examination of how motivational factors related to change and conflict within organisations and implied that at any one time the prevailing arrangements for management are likely to represent a negotiated rather than an imposed order and that renegotiation and change are intrinsic characteristics of all human institutions.

It was supposed that, where one group of actors was dominant in an organisation, then the objectives of that group would represent the underlying objectives and therefore the behaviour of the organisation as a whole.

The first step was to test perceptions in order to postulate the objectives of actors within NHS Trust organisations. A questionnaire was devised, after detailed interviews and piloting, and doctors and managers were approached directly through an England-wide survey administered by Trust Chief Executives.

The questionnaire survey, which produced 1,577 responses, was conducted in September/ October 1997, ahead of the Labour Government's White Paper published in December 1997 (Department of Health, 1977). The sample of respondents comprised 43% consultants and 57% managers, providing a cross-section of both groups. The survey revealed that consultants and managers harbour significant differences in their attitudes and perceptions. Consultants are the more homogeneous group while managers show greater complexity with a division between operational managers, described as service/business managers, and corporate managers comprising the Chief Executive and non-medical Trust Board directors[37]. Consultants are, indeed, driven by service goals although, rather surprisingly, service volume was consistently less important than service quality. Break-even and revenue expansion was unimportant to consultants. Managers ranked financial break-even as their most important goal but were less focused on this than consultants believed, since maintaining service quality

[37] Other central functions such as finance and contracting sat on a spectrum between the two groups.

was ranked a close second, revealing an attempt to balance these two objectives. The Trust as a whole, however, was perceived by all groups to pursue break-even as its unequivocal priority.

It was apparent from the questionnaire that the introduction of Trust status made a difference to the priorities of individuals and the organisation as whole. Doctors' objectives appear to be the least affected by the change since over 50% believed that their own priorities had remained unchanged or even weakened across a range of factors which included, for example, maintenance of service volume/quality. Managers, on the other hand, felt that their own objectives had gained in strength since Trust status. Both groups were agreed that the Trust had become more focused on its priorities and more energetic in their pursuit.

These responses support the underlying hypotheses about the difference between doctors and managers and their respective service and financial aims. They also show that both groups see the Trust as something distinctly different from themselves, since it is perceived as pursuing a set of objectives which are quite different from those of consultants and more stringent than those of managers; there is a clarity of view about the existing priorities of the Trust even though these are not owned by the dominant groups within the Trust. This begs the question of how the Trust can achieve its perceived goal of break-even when consultants believe it to rank low in the scheme of priorities and managers are ambivalent about its importance in relation to quality.

This ambivalence was highlighted by the responses of clinical managers and service/business managers, sub-categories of the overall group, to the question of their individual priorities. Although the highest mean ranking was attributed to *financial break-even* with *maintaining service quality* ranked second overall, closer inspection of the responses showed that the majority of service managers believed that *maintaining service quality* was their first priority. The high average ranking of *financial break-even* was achieved through the combination of first and second rankings, lifting the mean score. This group has service interests which are more akin to those of consultants. Their interest in financial management, however, sets them apart from consultants and ties them to the management body. Given that this group of managers has resource management responsibilities within Trusts, the analysis highlights the tension between meeting service demands and balancing budgets within NHS Trusts. This casts further doubt on Trusts' ability to achieve their statutory financial objectives, since the financial incentive is weakest of all among the managers who are employed to deliver the service and manage the budget.

The questionnaire asked individuals to consider whether the NHS climate was likely to change with the new Government, the extent to which this was welcomed and the sort of change they anticipated. 80% of respondents believed there would be some degree of change and 85% welcomed this. Doctors were the most emphatic in their desire for change since 48% wanted change 'very much' compared to 37% of the manager sample. Respondents were given the opportunity to state in their own words the sort of change they would like and

a strong pattern of responses emerged which was consistent with the government's subsequent White Paper. To this extent the claim in the 1997 White Paper that *'The new arrangements go with the grain of what NHS Trusts and their staff want'* (p53) is supported by the findings of this survey.

Both doctors and managers identified market reforms as the most popular change with 32% of respondents (501/1577) advocating abolition or amendment of the internal market. 5% of respondents specifically called for abolition of the two tier GP Fundholder system. Both measures subsequently became government policy. Second to market reform was a call by 26% of the sample for additional and better use of resources (403/1577) and, allied to this, was the proposal by 23% to reduce bureaucratic processes and eliminate management and transaction costs (356/1577). At the same time there was a call for a public debate about affordability of health care and rationing priorities (10%, 160/1577). The Government, however, is unequivocal in rejecting this in favour of efficiency gains: *'...the choice posed between unaffordable levels of funding or charges and rationing is a false dilemma....The NHS needs to make better use of its resources'* (Department of Health, 1977, p8). In response to the argument that the NHS cannot accommodate cost pressures and needs to increase funding or restrict care *'[t]he Government rejects this analysis. So do the public'* (p7).

Another major theme emerging from the same open question was a desire for collaboration to replace competition (162). The purchaser/provider split and competition among Trusts was felt to need reform, although only 4 out of 1,577 respondents called for Trusts to be abolished. A small but increased number (8) declared that Trusts were a good thing and a further group (11) wanted to develop Trust freedoms. It is reasonable to interpret these open question responses as a weariness and criticism of market structures but, if anything, an endorsement of local Trust freedoms which is consistent with the White Paper (1997) direction.

After market structure, resources, and bureaucracy the fourth most important change was described under the label 'priorities' (315/1,577). This broadly described the desire for a return to an NHS philosophy of universal provision and a public service ethos and was described in terms of quality and a requirement to put the clinical need of the patient first, irrespective of origin. It called for an attitudinal change through removal of business thinking and freedom of choice. This is encapsulated in the first of the key principles enumerated in the White Paper '*to renew the NHS as a genuinely national service. Patients will get fair access to consistently high quality, prompt and accessible services right across the country'* (Department of Health, 1977, p11). This area was closely related to responses grouped under the title 'influence and leadership' (274/1,577) comprising 20% of consultants (137/681) and 15% of managers (137/896). Respondents in general sought a more clinical/consultant/ professionally driven service and better quality leadership. The tension in organisational relationships was apparent within this category since a vocal minority (23) called for less consultant influence and intransigence.

The response to this question about change, however, needs to be weighed against the view (Questions 5 and 6) that 62% of respondents (914/1502) believed that relationships between consultants and managers had improved and 66% (997/1505) believed that services to patients had improved. The responses of doctors and managers diverged at this point with 48% (317/653) of consultants perceiving an improvement in relationships compared to 72% (597/849) of managers, although 'better' was the modal response of each group and only 28% of doctors believed that relationships had deteriorated. 58% of doctors (351/651) and 76% of managers (646/854) believed that services to patients had improved with, again, 'better' being the modal response. The main reason for the improvement in working relationships was described (through Question 5b) in terms of shared priorities and objectives, accounting for 37% of positive comments (324/865) and using phrases such as *'partnership'*, *'co-operation'* and *'collaboration'*. An identical proportion of negative comments (105/283) identified conflicting priorities as the reason for poorer relationships. Involvement of clinicians in management was used to account for better relationships by 28% (243/863) of positive respondents, most of whom admittedly were managers.

These responses show that there is a balance to be struck between reporting a strong desire for change and casting a light on developments over the previous seven years. Government policy since 1991 was seen to have produced positive change on doctor/manager working relationships but market structure and resource pressures were exerting their own forces which staff were keen to dismantle. The Labour Government captured the spirit of this desire for change, without acknowledging the debt to earlier developments starting with the Resource Management Initiative in 1986, by stating that *'[f]or the first time in the history of the NHS the Government will align clinical and financial responsibility to give all the professionals who make prescribing and referring decisions the opportunity to make financial decisions in the best interests of their patients'* (p9).

61% of respondents believed that the goals of doctors and managers had moved closer together (Question 7) with only 13% of managers and 29% of consultants believing that their goals had moved further apart. Taken with the other results, showing (a) that doctors' priorities had changed less than those of managers, (b) that relationships had improved through shared priorities and objectives and (c) that managers who were closest to consultants, i.e. clinical and service/business managers supporting the operating core, shared objectives which were closer to those of consultants than to those attributed to the Trust, it is possible to form an alternative notion of the result of bringing clinicians into management. The Resource Management Initiative (DHSS, 1986) began with the intention of involving clinicians in management to give them responsibility and information to enable them to manage resources better and to take greater resource management responsibility. The Labour Government's pledge to align clinical and financial responsibility follows the same direction of thought. The dynamics of motivation revealed by the questionnaire survey suggest that the impact of this may be the reverse of the Government's intention. Rather than consultants being converted into managers, the evidence suggests that managers are more likely to be converted by consultants. Consultant motivation has a consistency and clarity which appears

unmoved by health service reforms. Management goals show greater fluidity and diversity, and vary according to their proximity to the operating core and, thereby, proximity to consultants. (If doctors were to have a greater presence at the strategic apex then the evidence produced in this survey allows one to speculate that the goals of the Trust could be altered explicitly to reflect service goals and to reject financial constraints). Where power is delegated to the operating core, as envisaged by the Resource Management Initiative, then managerial priorities, it is demonstrated here, become subverted towards service needs.

12.3 Trust Behaviour

After considering the internal motivation of Trusts the programme of work went on to consider Trust behaviour. A study of 100 general acute Trusts was undertaken based on three years of Annual Accounts up to 1994/95 which were set alongside Department of Health activity data for the same financial years. The results were consistent with the hypotheses in that two thirds of Trusts which experienced revenue growth also succeeded in achieving both their financial target and a growth in service delivery. In these revenue-gaining Trusts managers failed in their postulated objective[38] 28% of the time while doctors failed only 9% of the time[39]. Where Trust income contracted, managers failed to meet the financial target in 38% of Trusts while doctors saw output reduction in only 9% of cases. The results showed that where income reduced then managers experienced greater difficulty in achieving the financial target performance since the service continued to expand at the expense of financial constraints. It was striking that doctors and managers succeeded in achieving their objectives simultaneously in the majority of cases, both where income rose and where income reduced, but this did not invalidate the conclusion that, where the aims of doctors and managers are mutually exclusive, doctors' behaviour tends to dominate.

The questionnaire survey had suggested that service volume was less important to clinicians than quality, indicating that doctors' primary motivation was based on quality of the service. This does not invalidate the quantitative results supporting the hypotheses which have been expressed in terms of volume since consultants observed volume to be more important to them than financial targets. The mean rankings showed consistency between consultants' view of themselves, consultants' view of other consultants and managers' view of consultants. The order of priority was determined as (1) maintaining quality, (2) expanding quality, (3) maintaining volume, (4) expanding volume and (5)/(6) expanding revenue/ breaking even. Hypotheses 1A-4A and the associated test remained valid in the light of the questionnaire responses since the secondary objective of service volume was shown to be adequate as a counter-objective to financial break-even[40].

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[38] Postulated as breaking-even to meet the Financial Target Performance set as 6% return on assets.

[39] It was postulated that doctors sought expansion of service volume (in the absence of quality measures).

[40] Depth of service in terms of investigations, technology and other levels of care associated with a single episode provides a possible method of framing quality in relation to volume and finance. Where extra funding is invested in this way rather than in expanding the service it could be argued that the hypothesis of quality taking precedence over quantity is supported.

12.4 Feedback from the External Environment

The third piece of empirical work used a case study approach to consider the behaviour of Trusts in the context of their external environment. It tracked through Kingston Hospital's behaviour in the early days of the internal market and showed its relationship with Epsom Hospital, considered to be a strong competitor with expansionist instincts to rival those of Kingston. The latter part of the period had been characterised by a strategic review of hospital services within South west London (excluding Epsom Hospital) which recommended closure of Queen Mary's Hospital on financial grounds. This was bitterly resisted by the Richmond, Twickenham and Roehampton Trust which owned Queen Mary's, drawing the community into a vociferous 'Save Our Hospital' campaign. The Trust was successful in thwarting a full-scale closure of the hospital but was deemed clinically non-viable as a District General Hospital and has since lost its acute hospital services.

Queen Mary's was located in the marginal constituency of Putney where David Mellor held the seat as a Conservative up to 1997. The case study portrayed the political imperatives which operate within the NHS environment and which, driven by MPs' accountability to the community, work to neutralise market forces. It also exemplified the weakness of financial incentives to produce change within the NHS in contrast to clinical objectives which, driven by doctors, had a clearer direction and greater impact.

Neutralisation of market forces stems from failure to close hospitals. Economic theory requires a competitive market structure driven by some form of financial motivation to sustain a competitive environment. The failure to deliver financial objectives in the internal market, witnessed by the political unwillingness to be seen to let financial targets override public wishes in the case of South west London, means that clinical priorities have greater impact. It is also contended here that this incentive structure will feed back to managers and consultants and will affect their motivation, encouraging a disregard for the already weak financial constraint. Political exigencies go further to weaken financial control, illustrated by Alan Milburn's commitment to the local CHC to redevelop the Queen Mary's site, requiring additional resources.

12.5 Implications of Results in Relation to Labour's Reforms

Managers and doctors were approached as two groups of individuals who are alike in their human qualities but are placed under different incentive structures by dint of their professional setting, reward patterns and lines of accountability.

The conventional view of *homo economicus* as a rational being who will make choices at the margin based on financial gain has been extended by public choice theorists who take the 'methodological individual' as the starting point of analysis and lay emphasis on narrow economic self-interest as the prime motivator of all actors in the public sector. This public choice approach to motivation is useful because it signals the role of incentives and allows us

to predict that, should the incentive structure change, actors will realign their secondary goals with the primary one of narrow self-interest. It also goes some way to explain why consultants, considered to be maverick and individualist in their behaviour, emerged as a homogeneous group through the questionnaire, since their professional status provides a uniform incentive structure. Managers proved to be the more heterogeneous group, reflecting their lines of accountability which differ between the corporate and service levels of the organisation. Consultants placed service issues, defined predominantly in terms of quality, squarely at the top of their list of priorities within the Trust while they ranked financial break-even as least important. Managers on the other hand purported to strive for financial balance, ranking it as their first priority, while balancing this with quality considerations which were also considered to be important.

12.5.1 Impact of Market Abolition

An analysis of market structure would suggest that consultants are entirely rational in their order of priorities since failure to break-even does not drive a Trust out of existence, contrary to competitive theory. The public choice approach supports the prediction that consultants would reshape their priorities in the event of a change in market structure. Figure 12.2 shows how managers' and doctors' objectives interact with the market environment and indicates that 1991-1997 has been marked by barriers to market exit; efficiency has not been rewarded by growth in market share and inefficiency has not been punished by failure through closure. In the balance between quality and cost-effectiveness it is therefore rational for doctors to pursue quality vigorously, reinforced by dependence upon reputation. Added to the balance of objectives held by managers, it is logical that the weight of motivation within Trusts should fall to pursuit of service rather than financial goals.

If, however, the link between Trust funding and performance were to prove more robust then there would be an incentive for consultants to reshape their objectives[41]. Interviews conducted in Stage 1 of the questionnaire fieldwork revealed the extent to which consultants depend on the NHS to pursue their aims. Surgeons rely on their NHS position to receive a stream of private patient referrals which generates the major part of their income. These referral patterns would be disrupted by any geographical reconfiguration of service through hospital closure. A real threat of closure through poor financial performance and, conversely, real reward through strong financial performance, would have a bearing on consultants' priorities and would raise the importance of *financial break-even* as an objective.

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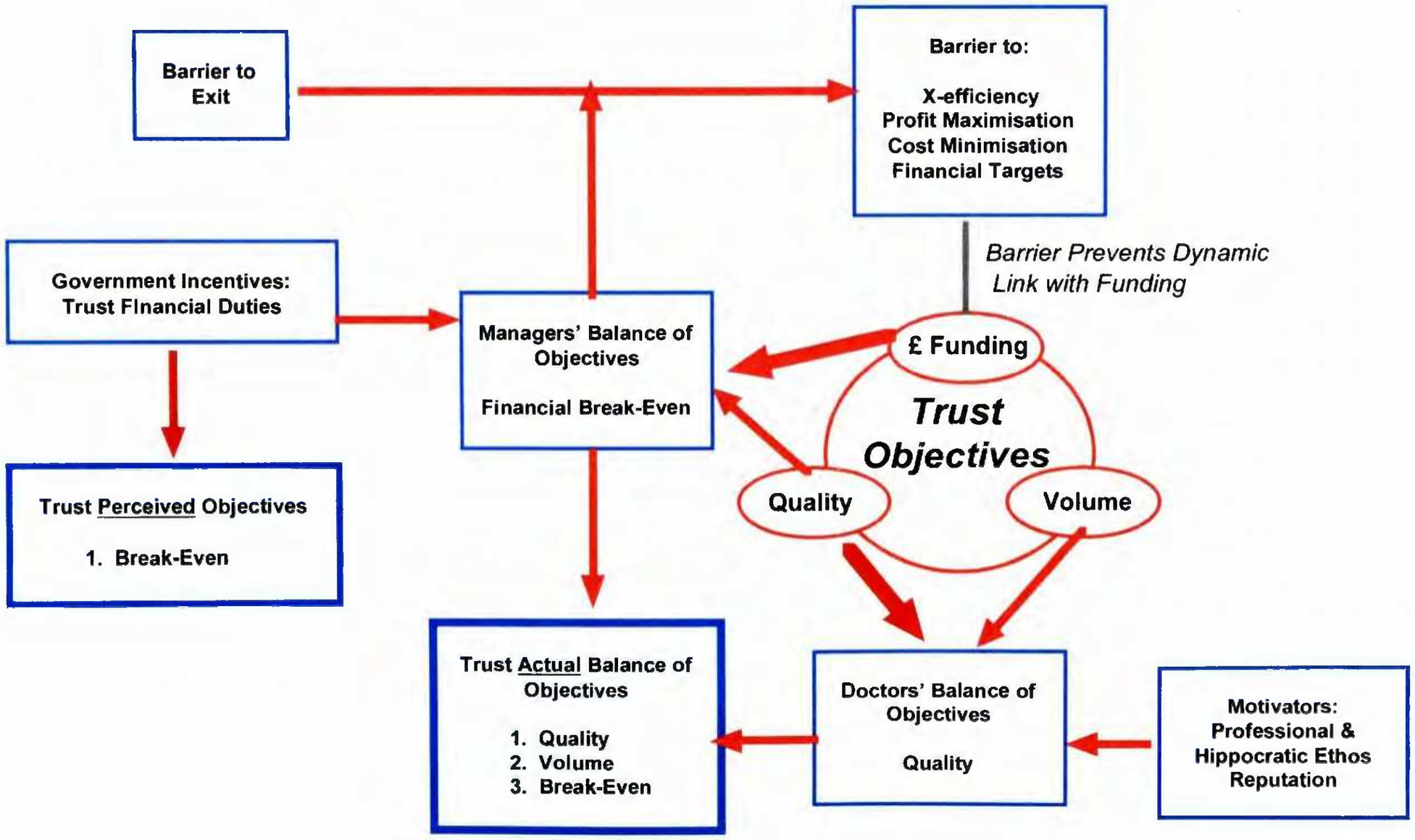
[41] If money really were to flow with the patient and hospitals allowed to close then the sequence of events in a general hospital would be (1) a shift in elective surgery which would (2) reduce the viability of surgical specialties in the losing hospital; (3) absence of surgery would make it impossible to run an accident and emergency department, resulting in (4) closure of accident and emergency and (5) shift of all general medical and other acute specialties to another centre.

Figure 12.2: 1991 - 1997 Incentive Structure & Objectives



In the light of this market dysfunction the question arises as to the impact of abolishing the internal market upon the motivation of Trusts. The answer would appear to be 'not much' since neither the incentive structure nor the market structure would change with abolition.

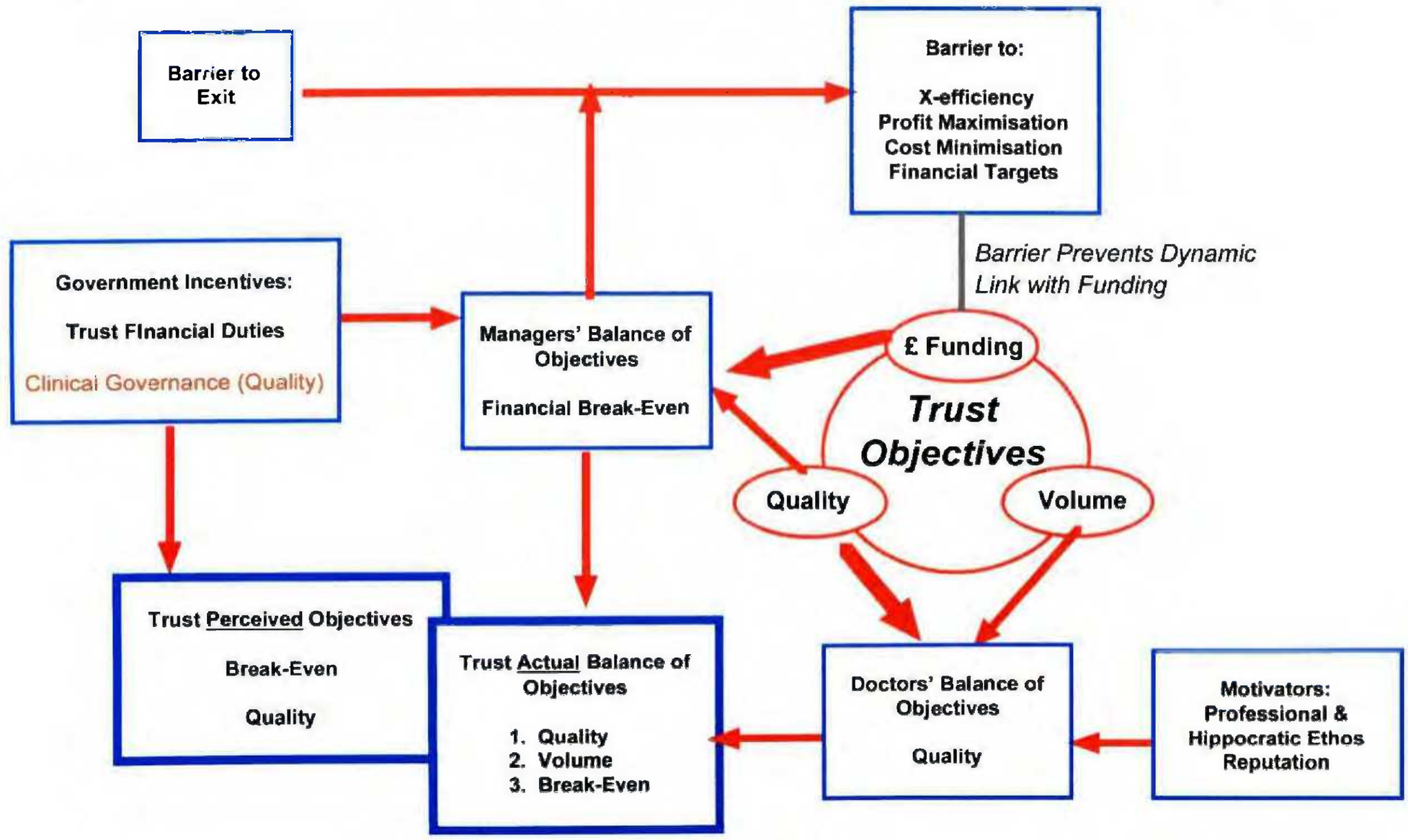
The survey demonstrated that the internal market was unpopular in a way which the purchaser/provider split was not, yielding proposals such as revised contractual arrangements between purchasers and providers as possible solutions. The White Paper (Department of Health, 1997) has captured this, declaring that *'[n]ot everything about the old system was bad'* (p11) and aiming to retain the '*separation between the planning of hospital care and its provision'* (p12) while still planning to abolish the internal market. This is consistent with the questionnaire responses but at the same time reveals a potential triumph of perception and tone over substance, (which in itself has a rationale in the context of the government's sixth key principle *'to rebuild public confidence'),* since the internal market cannot be defined as anything other than a system of resource allocation through agreements/contracts which separate purchasing or planning of the service from its provision.

The key to this conundrum must lie in the distinction between *'competition'* and *'partnership'*. The 1997 White Paper and questionnaire survey are in harmony by advocating the abolition of competition which would destroy the key driver of an internal market. The ethos of competition has stimulated a desire for survival based on a Darwinian struggle which was played out in the case study with, many felt, damaging consequences. The evidence of the case study, however, also illustrated the extent to which real competitive forces have been absent from the internal market, suggesting that 'competition' represents a policy intention that has never properly been executed. The case study revealed the degree of accountability faced by elected members of parliament towards their constituents who typically cherish their local hospital as a symbol of care, security and community identity. In short, the evidence suggests that there was no market, nor could there be, in a parliamentary democracy which will always serve to stunt unpopular manifestations of competition.

12.5.2 Clinical Governance and the Quality Instinct

Consultants and their priorities have apparently come through unscathed by the 1991 reforms due, on the one hand, to the stability of the incentive structure determined by occupational control and, on the other, to market behaviour through lack of exit, i.e. political difficulty in closing hospitals. In terms of Trust objectives, the Labour Government reform which promises greater impact than market abolition is the introduction of clinical governance. This is intended to balance the statutory objectives of finance with an emphasis on quality which, according to questionnaire responses, is consistent with the existing motivation and behaviour of both managers and doctors.

Figure 12.3: 1998 Onwards - Conjecture : Incentive Structure & Objectives



The Trust has been perceived as aiming for an uncompromising break-even position, in line with statutory duties defined by the NHS and Community Care Act 1990, whereas neither doctors nor managers have identified with this strident emphasis on financial targets. The empirical work thus highlighted the gap between Trusts' perceived objective, laid down in statute, and their actual objective produced by the interaction of the dominant actors. By bringing quality into the key target area and integrating perceptions with actual behaviour (Figure 12.3), it is reasonable to conjecture that the 1997 White Paper provides a resolution to this divergence between perceptions of Trust aims and reality as reflected by their performance.

Aside from this, clinical governance could succeed in influencing clinical behaviour in a way which market reforms did not. Professional status of doctors depends upon self-regulation which guards the 'indeterminacy' of its work (Fincham & Rhodes, 1992), preventing a shift of control to outside managerial elements. Professional censure is traditionally reserved for matters of ethics rather than competence and competence cannot be judged by outsiders while the profession monopolises knowledge. Clinical governance, though still in its infancy as a policy, could challenge this monopoly and in consequence reduce the status of the profession. The case for transparency and competence-based assessment was given a sharp boost by the Bristol Royal Infirmary scandal in 1998 in which the Chief Executive, while also a doctor, felt unable to challenge the rumoured incompetence of two paediatric cardiac surgeon colleagues.

The medical profession is at a juncture which sets at stake its ability to maintain occupational control through self-regulation and clinical autonomy. Any dilution of status will lessen the rewards to the profession and ultimately affect recruitment and the calibre of consultants. Clinical governance moves the target of reform firmly into the territory which doctors believe to be the most important, namely quality. If managers are seen to trespass onto this area then the frustration of 1991-97 could be replaced be greater turbulence, even though in principle clinical governance lends greater coherence to Trust motivation and behaviour. The outcome will depend upon the medical profession's ability to absorb clinical governance and continue to regulate itself successfully as a profession from within its own ranks.

12.5.3 Expansion of Trusts into the Primary Care Sector

This thesis has focused on secondary and (in the questionnaire survey) community care Trusts, the majority of which are acute hospitals, drawing attention to the motivation of consultants and managers. Primary Care Trusts (PCTs) come on stream from 1st April 2000, converting some Primary Care Groups formed under the 1997 White Paper which elect to become PCTs. Trusts will constitute groups of GP practices serving populations of up to 250,000 residents that will contract with the Health Authority as providers of primary and community services and will be purchasers of secondary and community services through contracts with other NHS Trusts.

Existing NHS Trusts and the new PCTs are similar in that doctors are the main professional group in each and that managers will also be required to martial resources and meet externally set targets. The PCT Boards will include doctors and managers and the Chief Executives of most PCTs for the most part will have managerial rather than medical backgrounds.

The analysis of motivation for NHS Trusts started from the premise that managers and consultants would act on the basis of self-interest, driven mainly by reputation (as shown in the questionnaire survey responses to Question 1). Their respective professional and performance incentives thereafter drove doctors to pursue quality and managers to balance the budget. (It was argued that professional regulations succeeded in aligning doctors' self-interest with the interests of the patient, bringing self-interest into line with altruistic concern). The market environment supplied feedback which reinforced the doctors' motivation and weakened the managers'. In summary, therefore, self-interest is the starting point and incentive structures motivate behaviour.

The shell of this analysis could be applied to PCTs, namely self-interest responding to incentives, but the putative behaviour is likely to vary due to significant differences in incentive structures relating to consultants and GPs. General practitioners are partners who each have a vote in decision making within the practice and, having bought a stake in the partnership through capital investment, share the profits of the enterprise. General practice draws income according to its list size and can enhance this by a range of activities such as meeting screening targets and running a dispensary. As in the GP Fundholding scheme which ran 1991-97 it is possible to put a *cordon sanitaire* around the commissioning budget to keep it ring-fenced and separate from the wider income-earning activities of the partnership (Glennerster *et al*, 1994) but the incentive to behave as a profit-making enterprise is embedded into the partnership structure. Hospital consultants, on the other hand, are salaried and, as interviews conducted in Stage 1 of the questionnaire fieldwork showed, may have lucrative private practices which depend on the NHS to ensure clinical reputation and provide a source of patient referral.

Consultants' income maximising motivation is channeled into their private practice, reducing the incentive towards supply-driven demand within the NHS. The salaried arrangement divorces consultants from the financial gains or losses of the Trust, justifying their lack of interest in financial management. A tension will arise in general practice over the impact of PCT deficits and surpluses upon the practice income. It will be entitled to retain surpluses of cash earmarked for secondary care use, suggesting that GPs will attempt to change their referral patterns to bring services in-house. Deficits will be monitored by Health Authorities in the first instance and thereafter by the Commission for Health Improvement (CHI) which could impose management changes where PCTs consistently fail to balance their budgets (Hausman and Le Grand, 1999). As in the case of hospital Trusts, the incentive structure for managers is supposedly clear but the strength of the budget constraint will depend upon feedback from the external environment. If the budget constraint proves to be weak and does

not impact upon GPs' personal finances then the same conflict between doctors and managers could arise in PCTs as in their secondary sector counterparts. The same professional and ethical culture will motivate both GPs and consultants and there will be no incentive to ration care to contain costs. If, on the other hand, the partnership earnings are affected by the financial performance of PCTs then this would present GPs with a potential conflict between their professional and their personal interests. General practice would become increasingly unattractive as a medical specialty and partners would leave primary care. This would stimulate growth of salaried workers and the consequent shortfall in GP numbers would be met by other professions, such as nurses, taking on functions of GPs. There is already a perceived 'crisis' affecting general practitioner recruitment and retention and a view that workload will shift from doctors to other health care practitioners (Cochrane *et al*, 1999).

A problem akin to 'herding cats' will arise if GPs are required to take a consistent approach to policy and practice. The case study of Kingston and Queen Mary's Hospitals in Chapter 11 showed that GPs within the Kingston and Richmond Multifund, the main GP Fundholding body within south west London, were divided on their attitudes to the two hospitals, with Kingston GPs supporting the cause of Kingston Hospital and Richmond GPs anxious to support Queen Mary's. The Health Authority at the outset (through the SW London Review of 1993) had recommended that Queen Mary's should close. Corporate behaviour above the level of GP practice would be difficult to secure within PCTs.

It is reasonable to conjecture that doctors and managers within PCTs will be driven by the same goals of quality on the part of doctors and financial discipline on the part of managers, with managers fighting a losing battle[42]. The relationship between partnership earnings and PCT surpluses adds a complication, however, which could stimulate changes in activity, encouraging GPs to divert work away from the secondary sector and into primary care. This would establish a challenge for Health Authorities which, experience has shown, want to maintain the viability of their local hospital. PCTs will compete with hospital Trusts for resources, pointing to an increase in the competitive forces at work in local health economies.

12.5.4 Competitive Forces

The word 'competition' has been eradicated from official policy vocabulary through the 'partnership' arrangements of the Labour Government's White Paper (Department of Health, 1997). The underlying structure of Health Authority purchasers and NHS Trust providers remains intact, with GP Fundholding being abolished by, in effect, imposing full compliance through participation of all GPs in Primary Care Groups (PCGs). The option to graduate from PCG to Primary Care Trust (PCT) will restore the differences between GPs which were associated with the old GP Fundholding scheme.

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[42] A progress report indicates that clinical governance is a key area of interest for PCGs, consistent with the notion that doctors are primarily interested in quality. *The Health Service Journal, 25th November 1999*, reports that *'... clinical governance committees are the most developed aspect of PCGs' structure, followed by prescribing, information technology and commissioning. The majority of committee members are GPs'* (p6).

The internal market in the NHS never functioned as a competitive market due, according to the analysis in this thesis, to lack of entry and exit from the market, shaped by politics and the strictures imposed by medical training regulations. Although the market did not work the 1991 reforms were, nevertheless, successful in introducing a competitive spirit through the survival instinct born in Trusts. Nothing of the role or management structure of Trusts has changed with the 1997 reforms. It follows that the competitive instincts of Trusts to survive, in the teeth of failure of neighbouring hospitals, remain intact. If PCTs adopt similar survival aims then intensity of competition for resources in the NHS will be heightened rather than dampened.

Trusts, it may be concluded from this thesis, compete on the basis of quality rather than price. Service developments will be promoted by clinicians on the basis of treatment quality rather than economic considerations, with the result that competition will increase costs. This is consistent with evidence from the United States in the period up to 1982 when hospitals were reimbursed, as many private hospitals are in the UK, on a retrospective cost-plus basis (Culyer and Posnett, 1990). Robinson and Luft (1985), for example, found that there was a positive relationship between competition and price. Unit costs were highest in the areas with the most competitive market structure. These results were confirmed in a subsequent study (Robinson and Luft, 1987) which found that hospitals with more than ten neighbouring hospitals within a fifteen mile radius reported average costs per admission 26% higher and average costs per day 15% higher than similar hospitals in a monopolistic market. The difference in observed cost per case widened to 35% for hospitals with more than ten neighbours.

The case study in Chapter 11 revealed pressure to purchase new MRI technology, illustrating how competitive markets would tend to drive up unit costs through investment and potential duplication of services. Reputation of the hospital and of the consultants themselves depends on the ability to demonstrate that a high quality service is being delivered. Competition therefore leads to increased inputs and increased unit costs[43].

If the effect of expanding the number of Trusts through PCTs is to increase competition, as suggested here, then it follows that the cost of health care will increase and the UK will be obliged to dedicate a greater proportion of GDP to this sector. While health care is mainly provided by the NHS and funded through taxation this implies that the Government will need to spend more money on health to meet increasing costs. Duplication of services between

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[43] An article by B Hollingsworth *et al*, November 1999, uses Data Envelopment Analysis (DEA) to analyse movements in productivity, efficiency and quality performance of hospitals since 1991. It suggests that quality, defined as standardised survival rates following admission for stroke, fractured neck of femur and myocardial infarction, has reduced. Technical change has increased, accounting for increases in productivity or volume of service. Efficiency, in the absence of technical change, showed a small decrease. These results are not inconsistent with the discussion of quality in this chapter since quality in this thesis is largely being defined in terms of inputs rather than mortality outcomes. Hollingsworth *et al* suggest that inputs have increased. It is reasonable to equate inputs with quality since it is likely to be consistent with the depth of treatment, producing an increase in access to previously unavailable treatments or investigations. MRI is a good example of this phenomenon.

secondary care Trusts which will have been stimulated by the internal market of 1991-1997 will, it is contended, be followed by duplication of services between primary care and secondary care Trusts. This could take the form of pathology equipment, for example, where near-patient testing takes place through new analysers purchased in primary care while large central pathology departments in acute hospitals continue to invest in new technology. Likewise, minor injuries clinics could be established within PCTs, running alongside accident and emergency departments in secondary Trusts. The signs are that quality, in terms of access to services for patients, will increase but that cost containment will prove to be impossible. Political stability for the Government will inevitably carry a price tag where the number of Trusts is growing.

12.6 Conclusion

The balance of influence within Trusts has been assessed through this work as lying with the consultant workforce. Doctors, it is concluded, are the dominant group within Trusts, producing a clash against the nominal objectives of Trusts which are to break-even. A budgetary constraint is recognised as existing within Trusts but its enforcement is weak when a conflict arises between service demands and cost containment. Managers are a more diverse and plastic group than the clinicians and there is evidence that their priorities have been moulded to a greater extent than clinicians' over the last ten years with the organisations' acquisition of Trust status. The relative constancy of consultants' priorities within the organisation comes as no surprise, given the stable nature of their professional and personal incentive structure over the same period.

The introduction of market reform through the purchaser/provider split was originally envisaged as a mechanism to bring about greater responsiveness to patient demands and to financial incentives. Money would follow the patient, rewarding the efficient and, by implication, moving resources away from the less cost-effective. But patient demand for health care has been defined as 'supplier-induced' since clinicians determine who receives what type of treatment within the NHS (Chapter 3). It is the professional-experts who define need, in contrast to bureaucratic-experts who are charged with increasing efficiency (Klein, 1989, p159). The conventional wisdom of this and the previous Government is that greater exposure to management responsibility and influence would produce a change in consultants' perceptions and behaviour. The Conservative Government demonstrated this through introduction of the Resource Management Initiative in 1986 and the current Government supported an alignment of financial and clinical duties in the 1997 White Paper. This notion, it could be argued, provides a rationale for the expansion of resource management responsibility into primary care through establishment of PCGs and PCTs. The empirical evidence of this study, however, indicates that exposure to management does not produce a marked change in doctors' motivation. Professional-expert-defined need does not metamorphose into bureaucratic-expert-defined (or constrained) demand. Rather, the reverse appears to be true. Closer proximity between consultants and managers in a decentralised organisational structure seems to shift the perceptions and aspirations of managers, producing

a gap between the motivation of those who are close to consultants and those who are apart at the strategic apex of the organisation. The impact of the 1997 White Pa proposals, therefore, described as a move towards quality through clinical governance and alignment of clinical and financial duties, will further weaken Trusts' drive to achi financial targets. At the same time, expansion of competition for resources through t entrance of PCTs to the health economy will, it has been argued here, inflate costs throu duplication of clinical facilities. The local impact will be to raise the cost of health c collectively between Trusts, achieved through the strength of clinicians' desire to maint and expand quality, and expressed as a drive to increase inputs through technology. Th pressures will be resolved only by fully funding Trusts' aspirations to maintain and impro quality by investing in service development.

This thesis concludes that the 1991 market reforms and subsequent 1997 reforms have dc nothing to alter the fundamental motivation of the dominant actors, namely doctors. A ta contract between the public and the medical profession remains in place through the fiduci duty of doctors to care for patients, in return for which doctors are allowed to be s regulated. The democratic system of locally elected politicians adds strength to this contra since the public exerts a voice through the ballot box. Hence, expert-defined need m ultimately be supported by Members of Parliament. This was highlighted in the case stu which showed that it was critical to secure clinical approval before shifting resour between hospitals. Once this approval was obtained, as in the case of Queen Mary's a Kingston, it was possible to achieve some change. But the overall thrust of expert-defi need is based upon quality, according to the evidence of this thesis, which requires m resources. To avoid financial crisis and conflict in the NHS, given the incentive struct which has remained unchanged for patients and doctors since 1948, the Government has option but to let 'good times' prevail.

12.7 Post Script

Expenditure data recorded in this thesis, coupled with recent events relating to health serv funding, supports this interpretation. The health service budget 1949-1988 had quadrup (Chapter 2). Forecasts to 2,000 suggest a six-fold increase in resources since 1949, w costs of £45 billion at current prices. The March 2000 Budget Statement by the Chancel of the Exchequer, Gordon Brown, promised a further large injection of funding, averagi 6.1% per annum, between 2000/01 and 2003/04, taking spending to £68.8 billion by the e of the period. The Health Service Journal (23rd March 2000) reflected the national sense amazement at the Government's actions:

'Budget beyond wildest dreams

Chancellor leaves pundits gasping with huge vote of confidence in NHS

Mr Brown has left all [the pundits] agape. Annual growth of 6.1 per cent above inflat every year until 2003/04 is indeed, as he said, the largest sustained funding increase in N history, and should all but fulfil the prime minister's pledge to reach European spendi levels. Worries about the size of the year-end deficit have been blown to oblivion in

instant.... As HSJ goes to press we await the details of the prime minister's announcements about how the cash is to be spent. Whatever they are, it will be down to NHS managers now to make it work.'

The work of this study suggests that there is no point at which managers will be able to 'make it work' once and for all, since continued increases in funding are needed to avoid conflict with clinicians. The incentive structure is such that the degree of resources needed to sustain this climate of growth is entirely open-ended since there is no check in the system to set a limit upon expert-defined need. What is more, the analysis of the 1997 reforms introducing Trust status to primary care suggests that further inflationary pressures are being built into the system which will work against cost-containment. By responding to political pressure to let good times roll the Government may be surprised and frustrated to find that it can never keep pace with expert-defined expectations. When it comes to curbing expenditure, managers at the apex of the organisation do not have the ability, and at the operating core do not have the desire, to exert control. There will be no resolution to this problem while existing public and professional incentive structures remain intact.

The London School of Economics and Political Science

WHAT DRIVES THE TRUST?

THIS QUESTIONNAIRE WILL TAKE ABOUT 10 MINUTES TO COMPLETE

This questionnaire asks you to consider your own priorities and those of all managers and consultants in the Trust. It has been designed to be simple to fill in, but the analysis will yield important insights about Trust behaviour within the internal market.

Background The internal market reforms introduced a financial motive into the health system, which unsettled the public and many staff within the health service. They feared that money would overshadow clinical values once a provider became a Trust.

Reality We know, in fact, very little about the motivation and behaviour of Trusts. There is little empirical evidence to tell us what drives clinicians or managers, or how service and financial priorities are weighted.

Policy Development We are now at a turning point in health care policy. It is important to collect evidence about your attitudes and experience to understand more clearly how the market works within the NHS.

Participation You are one of a selected number of people within the Trust who have been asked to participate in this national study, through the Chief Executive's office. Your participation is voluntary and immensely valuable.

Timing & Results Pilots show that this questionnaire takes on average about 10 minutes to complete. It would be helpful if you could fill it in and return it within two weeks of receipt. The results will be published and your Trust will receive direct feedback.

All information will be anonymised and treated in confidence.

Thank you for completing this questionnaire. Should you have any queries, please contact Tessa Crilly on 0181-677-7046.

Please return your response to:

LSE Questionnaire, PO Box 16566, London, SW16 6WA

Your Specialty/Division: 5644

Trust Name :

You are *(please tick all boxes which apply to you)*:

- ◻ CEO
- ◻ Chairman
- ◻ Board Director
- ◻ Consultant - Chair of Clinical Directorate
- ◻ Consultant
- ◻ Clinical Professional (non-medical)
- ◻ Corporate Manager_____
- ◻ Service/Business Manager (inc clinician)
- ◻ Other _____

How is your time distributed between ...?
(Approximate percentage split)

Management _____ Clinical _____ Other (R&D/Teaching) _____

Are you a budget holder ? ◻ Yes ◻ No

If yes, what is the approximate annual value of your budget? _____

Q1. To what extent does your own career depend on the following factors?

Please circle the word which, in your view, applies:

A financially successful Trust	V. Low	Low	Moderate	High	V. High
Success of your specialty /dept. within the Trust	V. Low	Low	Moderate	High	V. High
Strength of your specialty/profession nationally	V. Low	Low	Moderate	High	V. High
Individual reputation	V. Low	Low	Moderate	High	V. High
Reputation of Trust/hospital	V. Low	Low	Moderate	High	V. High
Standard of R&D or teaching	V. Low	Low	Moderate	High	V. High
Survival of the Trust as an organisation	V. Low	Low	Moderate	High	V. High
Continued provision of the Trust's clinical service	V. Low	Low	Moderate	High	V. High
Other (specify)	V. Low	Low	Moderate	High	V. High

Q2. Within the Trust, how would you rank the priorities for the following sets of people?

This question asks for the order of priorities which, in your view, is held by these groups.
For each column please rank priorities in order 1, 2, 3 etc where 1 is the most important.
*If you tie values, then please adjust rankings, e.g. 1,2,**3,3**,5,6.*

	You	Most Business & Service Managers	Most Consultants	The Trust Now	The Trust Ideally
Break-even financially					
Maintain service volume					
You may tie these if you wish					
Maintain service quality					
Expand revenue					
Expand service volume					
You may tie these if you wish					
Expand service quality					
Other (please specify) e.g. innovation, teaching, R&D					
_____					

Q3a. Which body, do you think, is achieving its main objective at the moment?
You may tick more than one:

❒ Managers ❒ Consultants ❒ Trust ❒ None

Q3b. Which body, do you think, will achieve its main objective during the next 3 years?
You may tick more than one:

❒ Managers ❒ Consultants ❒ Trust ❒ None

Q3c. Which body, do you think,will achieve its main objective during the next 6 years?
You may tick more than one:

❒ Managers ❒ Consultants ❒ Trust ❒ None

Q4. How have priorities changed since the organisation became a Trust? Have they become
(please tick the word which applies to you and then the word which applies to the Trust):

	Your Priorities			Trust's Priorities		
Break-even financially	Weaker	No change	Stronger	Weaker	No change	Stronger
Maintain service volume/quality	Weaker	No change	Stronger	Weaker	No change	Stronger
Expand service volume/quality	Weaker	No change	Stronger	Weaker	No change	Stronger
Be responsive to patients	Weaker	No change	Stronger	Weaker	No change	Stronger
Be responsive to GPs	Weaker	No change	Stronger	Weaker	No change	Stronger
Other (specify)	Weaker	No change	Stronger	Weaker	No change	Stronger

Q5a. Since the change to Trust status, has the relationship between consultants and managers become...?

❒ Much worse ❒ Worse ❒ No change ❒ Better ❒ Much Better

Q5b. Why?

_____

_____

_____

Q6a. Since the change to Trust status, has the service to patients become .....?

❒ Much worse ❒ Worse ❒ No change ❒ Better ❒ Much Better

Q6b. Why?

_____

_____

_____

Q7. Since the change to Trust status, do you think the goals of consultants and managers have .....?

❒ Moved closer together ❒ Not changed ❒ Moved further apart

Q8. Which group, in your view, has the <u>most control</u> over the following aspects of service?
(please circle the name which applies)

(a) Development of service :
Consultants Nurses Managers Chief Exec Trust Board Purchasers Other (Specify) .....

(b) Availability of facilities (e.g. beds, theatres) :
Consultants Nurses Managers Chief Exec Trust Board Purchasers Other (Specify) .....

(c) Medical staffing levels :
Consultants Nurses Managers Chief Exec Trust Board Purchasers Other (Specify) .....

(d) Nurse staffing levels :
Consultants Nurses Managers Chief Exec Trust Board Purchasers Other (Specify) .....

(e) Freedom to admit in-patient :
Consultants Nurses Managers Chief Exec Trust Board Purchasers Other (Specify) .....

(f) Decision to treat patient :
Consultants Nurses Managers Chief Exec Trust Board Purchasers Other (Specify) .....

Q9. Do you think the NHS climate will change with the new government?

❒ No - there will be little change ❒ Yes - there will be some change ❒ Yes - significant change

Q10a. Would you welcome change in the future?

❒ Yes - Very Much ❒ Yes - Probably ❒ Not sure ❒ No - Probably Not ❒ No - Definitely Not

Q10b. Why?

Q10c. What sort of change?

Thank you for giving your views.

Please return this to ***LSE Questionnaire, PO Box 16566, London SW16 6WA***

The London School of Economics and Political Science

TRACKING SHEET

A record of the individuals who have received a Questionnaire

Questionnaires are to be returned directly to the LSE.
This sheet provides a record of the people expected to respond to the survey.
Please identify the individual and tick whether they are a consultant or manager.

No.	Name/Position	Consultant	Manager
5641			
5642			
5643			
5644			
5645			
5646			
5647			
5648			
5649			
5650			
5651			
5652			
5653			
5654			
5655			
5656			
5657			
5658			
5659			
5660			

Thank you for completing this tracking sheet. Should you have any queries, please contact Tessa Crilly on 0181-677-7046

Your Name :	Telephone No.
Trust Name:	

Please return this Tracking Sheet to:

LSE Questionnaire, PO Box 16566, London, SW16 6WA

Participation

Appendix 1a

Trust No.	Name	No. Qs	Responses	Response Rate	Type	Wave
1	Aintree Hospitals	20	16	80%	1	2
2	Ashford Hospitals	20	6	30%	1	2
3	Bolton Hospitals	20	12	60%	2	4
4	Bradford Hospitals	20	7	35%	2	1
5	Brighton Health Care	20	13	65%	2	3
6	Burnley Health Care	20	5	25%	1	2
7	Carlisle Hospitals	20	3	15%	2	4
8	Chelsea & Westminster	20	17	85%	2	4
9	Countess of Chester	20	7	35%	1	3
10	Doncaster Royal Infirmary	20	14	70%	3	2
11	Basildon & Thurrock	20	12	60%	2	2
12	Barnsley District General Hospital	20	17	85%	2	3
13	Burton Hospitals	20	15	75%	2	3
14	Central Middlesex	20	14	70%	2	1
15	Cheviot & Wansbeck	20	8	40%	1	4
16	East Surrey Healthcare	20	16	80%	1	3
17	East Yorkshire Hospitals	20	7	35%	2	3
18	Frimley Park Hospital	20	3	15%	2	3
19	Hammersmith Hospitals	20	18	90%	2	4
20	Hastings & Rother	20	14	70%	1	2
21	Heatherwood & Wexham Park	20	15	75%	2	2
22	Hinchingbrooke Health Care	20	7	35%	2	3
23	Ipswich Hospital	20	16	80%	2	3
24	James Paget Hospital	20	10	50%	2	3
25	Kettering General Hospital	20	15	75%	2	4
26	Mid Kent Health Care	20	10	50%	2	3
27	Mid Sussex	20	15	75%	2	4
28	Mount Vernon	20	14	70%	2	4
29	Newham Health Care	20	14	70%	2	4
30	Norfolk & Norwich Health Care	20	18	90%	2	4
31	North Hertfordshire	20	7	35%	1	1
32	North Hampshire Hospitals	20	11	55%	1	1
33	Mid Cheshire Hospitals	20	11	55%	2	1
34	Leicester General	20	15	75%	2	3
35	Lancaster Acute Hospitals	20	11	55%	2	2
36	North East Lincolnshire	20	9	45%	1	3
37	Great Ormond St	20	13	65%	5	4
38	Good Hope Hospital	20	11	55%	2	3
39	Kings Lynn & Wisbech Hospitals	21	17	81%	2	2
40	Alexandra Health Care	20	7	35%	2	4
41	Derby City General Hospital	20	15	75%	2	3
42	Mid Essex Hospital Services	20	11	55%	2	2
43	Kings Mill Centre	20	16	80%	1	4
44	Huddersfield	20	10	50%	1	3
45	Halton General Hospital	20	13	65%	2	3
46	Freeman Group of Hospitals	20	11	55%	2	1
47	Frenchay Health Care	20	12	60%	1	2
48	Ealing Hospital	20	13	65%	2	2
49	George Eliot Hospital	20	14	70%	2	4
50	Blackpool Victoria Hospital	20	10	50%	2	4
51	Birmingham Heartlands	20	11	55%	2	2
52	King's Healthcare	20	12	60%	2	3
53	North Tees Health	20	19	95%	1	2
54	Oldham	21	18	86%	1	2
55	Oxford Radcliffe Hospitals	20	6	30%	2	4
56	Plymouth Hospitals	20	6	30%	2	4
57	Darlington Memorial Hospital	21	11	52%	2	4
58	Queen Mary's Sidcup	20	12	60%	2	3
59	Premier Health	20	12	60%	1	4
60	Peterborough Hospitals	20	12	60%	2	3
61	Queens Medical Centre, Nottingham	26	18	69%	2	3
62	Rochdale Health Care	20	6	30%	2	2
63	Sandwell Health Care	20	14	70%	2	4
64	Royal Victoria Hospitals	20	19	95%	2	4
65	West Middlesex Hospital	20	7	35%	2	3
66	South Buckinghamshire	20	6	30%	1	3
67	Thanet Health Care	20	15	75%	2	3
68	Northern General Hospital	20	13	65%	2	1
69	Preston Acute Hospitals	20	14	70%	2	4
70	Walsgrave Hospital	20	13	65%	2	3
71	Redbridge Healthcare	20	10	50%	1	3
72	North Devon Healthcare	20	11	55%	1	1
73	Royal Shrewsbury Hospitals	20	11	55%	2	4

Trust No.	Name	No. Qs	Responses	Response Rate	Type	Wave
74	South Devon Healthcare	20	16	80%	1	1
75	South Kent Hospitals	20	6	30%	2	4
76	South Manchester Hospitals	20	15	75%	2	4
77	South Tees Acute Hospitals	20	3	15%	2	2
78	South Tyneside Health Care	20	13	65%	1	3
79	Southend Health Care	20	15	75%	2	1
80	Southmead Health Services	20	9	45%	1	2
81	St Mary's Hospital, Paddington	20	15	75%	2	3
82	St Peter's Hospital, Chertsey	20	11	55%	1	2
83	Swindon & Marlborough	20	7	35%	2	4
84	United Leeds Hospitals	20	11	55%	2	1
85	University College London Hospitals	20	11	55%	2	4
86	Warrington Hospital	20	7	35%	2	3
87	Walsall Hospital	20	16	80%	2	1
88	Wellhouse	20	8	40%	1	2
89	West Lancashire	20	7	35%	1	3
90	West London Healthcare	20	11	55%	1	3
91	Northampton General Hospital	20	15	75%	2	4
92	Wirral Hospital	20	10	50%	2	1
93	Wigan & Leigh Health Services	20	15	75%	1	3
94	Worcester Royal Infirmary	20	18	90%	1	4
95	Princess Alexandra Hospital	20	8	40%	2	5
96	Homerton Hospital	20	3	15%	2	5
97	Grantham & District Hospital	20	7	35%	2	5
98	Salford Royal Hospitals	20	15	75%	2	4
99	Epsom Health Care	40	21	53%	2	1
100	Harrow & Hillingdon Healthcare	20	11	55%	2	4
101	North Downs Community Health	20	11	55%	3	4
102	Leicestershire MH Service	20	9	45%	4	4
103	Kingston & District Community	20	4	20%	3	4
104	Hounslow & Spelthorne	20	15	75%	3	3
105	Eastbourne & County Healthcare	20	9	45%	3	3
106	Herefordshire Community Health	20	8	40%	3	2
107	Community Health Sheffield	20	12	60%	3	4
108	Nottingham Healthcare	20	13	65%	3	4
109	Portsmouth Health Care	20	10	50%	3	4
110	Lifespan Cambridge	20	12	60%	3	3
111	Trafford Healthcare	20	13	65%	1	4
112	Ravensbourne Priority Health	20	2	10%	4	2
113	Plymouth Community	20	11	55%	3	2
114	Nottingham Community Health	20	10	50%	3	2
115	Northgate & Prudhoe	20	15	75%	4	4
116	Northampton Community Healthcare	20	13	65%	3	4
117	Oxleas	20	16	80%	3	4
118	Riverside Mental Health	20	1	5%	4	3
119	Severn	20	2	10%	3	3
120	Southern Birmingham Community Health	20	5	25%	3	4
121	Southampton Community Health Services	20	4	20%	3	3
122	South Durham Healthcare	20	8	40%	3	4
123	Thameside Community Healthcare	20	13	65%	3	3
124	North Hampshire Loddon Community	20	6	30%	3	3
125	Newham Community Health Services	20	15	75%	2	4
126	West Lambeth Community Care	10	10	50%	3	2
127	Communicare	10	1	10%	3	4
128	Scunthorpe Community Health Care	10	4	40%	3	3
129	South Cumbria Community & MH	15	6	60%	3	3
130	South Birmingham Mental Health	20	5	33%	4	4
131	Bethlem & Maudsley	18	3	15%	4	4
132	Bedford & Shires Health Care	20	12	67%	1	3
133	Bath & West Community	20	13	65%	4	2
134	Tower Hamlets Healthcare	10	14	70%	3	5
135	First Community Health	10	5	50%	3	1
136	Coventry Healthcare	20	8	80%	3	4
137	North Mersey Community	20	6	30%	3	2
138	Royal Liverpool Children's	20	15	75%	5	1
139	Nuffield Orthopaedic Centre	20	14	70%	5	1
140	Moorfields Eye Hospital	10	14	70%	5	4
141	Birmingham Women's Health Care	20	7	70%	5	4
142	Birmingham Children's Hospital	20	14	70%	5	5
143	Papworth Hospital	1	13	65%	5	3
144	Stoke Mandeville	**2823**	1	100%	2	4
	Total		**1577**	**56%**		

Appendix 2 *National Survey: Summary of Responses from Full Sample, Showing Doctors and Mangers as Two Separate Groups*

Appendix 2a *National Survey: Summary of Responses from Doctors' Sample, Showing Separate Categories of Doctors*

Appendix 2b *National Survey: Summary of Responses from Managers' Sample, Showing Separate Categories of Managers*

Appendix 2c *Stage 1 of the Questionnaire Survey: Summary of Responses to Question 2 from Site A*

Appendix 2d *Stage 3 of the Questionnaire Survey: Summary of Responses from Hospitals A and B*

National Survey: Summary of Responses from Full Sample, Showing Doctors and Managers as Two Separate Groups

		1a	1b	1c	1d	1e	1f	1g	1h	1j	2a	2b	2c	2d	2e	2f	2g	2h	2j	2k	2m	2n	2p	2q	2r
	Sample Mean	3.424	3.9676	3.4135	4.1936	3.6215	3.0755	3.6828	4.0226	4.3478	2.8364	2.6616	2.065	3.7211	3.4495	2.5047	3.209	1.8559	2.43	2.7333	3.0194	3.3293	3.5523	4.8675	4.5662
	Sample Standard Deviation	1.0319	0.8622	0.9624	0.7562	0.8055	1.0324	1.071	0.9128	0.8738	1.8942	1.5625	1.4125	1.726	1.7624	1.5428	1.9263	1.1865	1.3578	1.4773	1.5118	1.5485	1.6569	1.8458	1.4533
	Doctors Mean	2.9292	3.6618	3.5272	4.0956	3.5404	3.385	3.2946	3.96	4.3623	3.9081	2.7539	1.7757	4.076	3.4719	2.1244	2.9697	1.5571	2.5055	3.0671	2.7984	3.4193	3.9681	5.2228	4.8013
	Doctors Standard Deviation	1.0459	0.9386	0.8918	0.8291	0.8254	0.9574	1.1257	0.9082	0.874	1.5794	1.5877	1.2645	1.7795	1.8315	1.3407	1.7629	0.9185	1.2968	1.4514	1.4454	1.5713	1.6353	1.7257	1.4978
	Managers Mean	3.8018	4.2086	3.3241	4.2685	3.6836	2.8366	3.9797	4.0707	4.3391	2.0366	2.5934	2.2806	3.4574	3.4329	2.792	3.4591	2.0798	2.3737	2.4843	3.1848	3.2624	3.2413	4.5455	4.5402
	Managers Standard Deviation	0.8449	0.7099	1.0059	0.6864	0.7846	1.0252	0.9235	0.9139	0.8775	1.2866	1.541	1.4778	1.637	1.7102	1.622	2.0562	1.3095	1.3997	1.4478	1.5398	1.5289	1.6049	1.9031	1.4197
	Frequencies																								
Doctors	Score 1	65	18	14	6	11	24	42	10	2	45	194	404	72	123	285	111	438	183	117	135	99	61	13	16
	Score 2	158	54	69	20	55	87	130	37	0	82	127	120	72	94	164	63	97	196	125	175	89	69	15	34
	Score 3	258	182	215	98	228	242	196	121	6	140	120	53	88	115	89	93	89	150	156	133	134	115	39	108
	Score 4	154	313	307	331	326	254	208	309	24	156	98	31	128	123	56	45	20	75	103	120	131	116	37	130
	Score 5	43	112	74	225	59	71	103	198	37	122	71	32	121	82	29	44	4	42	121	39	127	121	91	158
	Score 6	0	1	0	0	0	0	0	0	0	87	28	8	117	57	17	20	2	14	19	34	41	137	36	127
	Score 7	0	0	0	0	0	0	0	0	0	41	8	3	46	46	1	20	0	1	0	4	11	7	128	63
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*678*	*680*	*679*	*680*	*679*	*678*	*679*	*675*	*69*	*653*	*646*	*651*	*645*	*640*	*643*	*396*	*648*	*641*	*641*	*640*	*632*	*626*	*359*	*636*
Managers	Score 1	7	6	38	3	5	81	15	15	3	429	268	359	116	137	264	92	409	293	271	126	114	145	24	21
	Score 2	52	10	131	11	43	256	37	42	2	170	232	227	162	156	155	63	175	248	244	195	194	172	41	46
	Score 3	224	80	305	71	299	310	186	121	7	164	146	110	176	178	140	51	149	144	143	186	183	157	50	151
	Score 4	432	469	293	464	422	185	362	387	44	59	95	79	178	134	137	44	89	79	92	196	155	151	38	149
	Score 5	173	298	97	341	119	45	287	312	59	34	87	82	120	133	101	55	27	70	79	59	128	126	79	278
	Score 6	0	0	0	0	0	0	0	0	0	18	36	30	92	100	49	30	14	23	27	82	70	83	44	151
	Score 7	0	0	0	0	0	0	0	0	0	1	9	6	23	26	5	43	1	2	3	10	8	3	75	62
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	0	1	1
	Sample Size	*888*	*863*	*864*	*890*	*888*	*877*	*887*	*877*	*115*	*875*	*873*	*873*	*868*	*864*	*851*	*379*	*864*	*859*	*859*	*855*	*850*	*837*	*352*	*859*
Total	Score 1	72	24	52	11	16	105	57	25	5	474	462	763	188	260	549	203	645	456	388	261	213	206	37	37
	Score 2	210	64	200	31	98	343	167	79	2	252	359	347	234	250	319	126	272	444	369	370	283	241	56	80
	Score 3	482	262	520	167	527	552	382	242	13	304	266	163	264	293	229	144	238	294	299	319	317	272	89	259
	Score 4	586	782	600	795	748	439	570	696	68	215	193	110	306	257	195	89	109	154	195	318	286	267	75	279
	Score 5	216	410	171	566	178	116	390	510	96	156	158	94	241	215	130	99	31	112	200	98	255	247	170	436
	Score 6	0	1	0	0	0	0	0	0	0	85	64	38	209	157	66	50	16	37	46	116	111	220	80	278
	Score 7	0	0	0	0	0	0	0	0	0	42	17	9	69	72	6	63	1	3	3	14	17	10	203	125
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	1	0	0	0	1	0	0	1	1
	Sample Size	*1566*	*1543*	*1543*	*1570*	*1567*	*1555*	*1566*	*1552*	*184*	*1528*	*1519*	*1524*	*1513*	*1504*	*1494*	*775*	*1512*	*1500*	*1500*	*1495*	*1482*	*1463*	*711*	*1495*

National Survey: Summary of Responses from Full Sample, Showing Doctors and Managers as Two Separate Groups

		2s	2t	2u	2v	2w	2x	2y	2z	2aa	2ab	2ac	2ad	2ae	2af	2ag	2ah	2aj	2ak	2am	2an	3aM	3aC	3aT	3aN
	Sample Mean	2.6783	2.0698	4.1528	2.962	2.2241	3.0484	1.4867	2.58	2.8762	2.8808	3.4068	3.6589	4.4202	2.4882	3.0872	2.6834	3.2214	2.9786	2.3336	3.2871	1	1	1	1
	Sample Standard Deviation	1.484	1.3832	1.7123	1.5747	1.3301	1.6367	0.9632	1.4362	1.5086	1.5019	1.5797	1.6849	1.9243	1.6975	1.8197	1.7369	1.8979	1.7431	1.481	1.7883	0	0	0	0
	Doctors Mean	2.5647	1.7559	4.2452	3.1543	2.1262	3.2632	1.4789	2.6481	3.1072	2.7663	3.4588	3.9385	4.8139	2.9105	3.175	2.6088	3.3156	3.0245	2.265	3.3819	1	1	1	1
	Doctors Standard Deviation	1.444	1.1982	1.8424	1.5444	1.2769	1.6753	0.9661	1.3679	1.4784	1.4424	1.565	1.6704	1.8679	1.8238	1.7888	1.8939	2.0145	1.8137	1.4606	1.7659	0	0	0	0
	Managers Mean	2.7822	2.3003	4.0848	2.8214	2.2969	2.8469	1.4925	2.5299	2.7069	2.9658	3.3688	3.4522	4.0402	2.1774	3.0226	2.7384	3.1516	2.9449	2.3845	3.1958	1	1	1	1
	Managers Standard Deviation	1.5082	1.463	1.6073	1.5826	1.3645	1.5753	0.9616	1.4833	1.5054	1.5399	1.5903	1.6665	1.9039	1.5263	1.8405	1.7668	1.8046	1.6898	1.4948	1.8074	0	0	0	0
	Frequencies																								
Doctors	Score 1	206	391	52	111	259	87	459	131	101	128	90	65	15	206	152	247	183	173	275	64	236	221	301	244
	Score 2	122	110	68	119	170	70	110	211	147	199	85	74	30	93	104	92	75	107	118	63	0	0	0	0
	Score 3	141	63	99	133	106	94	41	132	128	107	142	101	59	113	111	96	85	100	89	80	0	0	0	0
	Score 4	94	37	95	135	55	46	10	85	116	122	122	125	46	74	77	62	81	95	70	56	0	0	0	0
	Score 5	52	20	151	85	21	68	12	45	100	41	124	115	76	74	101	81	80	67	44	52	0	0	0	0
	Score 6	16	10	109	25	8	18	6	19	32	24	45	123	21	37	52	32	73	37	18	26	0	0	0	0
	Score 7	3	0	52	13	5	17	1	5	1	8	11	15	113	29	19	5	43	32	1	23	0	0	0	0
	Score 8	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0
	Sample Size	*634*	*631*	*627*	*622*	*626*	*380*	*639*	*628*	*625*	*629*	*619*	*618*	*360*	*626*	*617*	*616*	*621*	*611*	*615*	*364*	*236*	*221*	*301*	*244*
Managers	Score 1	243	367	61	231	311	94	620	243	214	172	124	131	40	430	261	317	206	214	334	89	446	327	575	170
	Score 2	166	176	87	180	230	97	127	278	245	201	160	144	54	136	149	140	155	191	172	67	0	0	0	0
	Score 3	176	130	171	163	145	98	74	135	158	168	169	154	64	128	87	93	133	128	119	72	0	0	0	0
	Score 4	128	87	151	122	72	49	19	83	96	173	165	160	53	67	106	95	143	122	102	45	0	0	0	0
	Score 5	118	80	208	107	64	38	14	69	99	69	141	129	73	54	142	124	88	109	73	60	0	0	0	0
	Score 6	28	14	129	38	20	18	6	38	35	52	75	106	33	24	76	60	78	51	25	26	0	0	0	0
	Score 7	1	5	42	10	0	11	1	7	6	11	12	12	56	11	18	8	34	20	2	19	0	0	0	0
	Score 8	0	0	2	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0
	Sample Size	*658*	*659*	*851*	*851*	*842*	*405*	*861*	*853*	*853*	*847*	*846*	*836*	*373*	*851*	*839*	*837*	*838*	*835*	*827*	*378*	*446*	*327*	*575*	*170*
Total	Score 1	449	758	113	342	570	161	1079	374	315	300	214	196	55	636	413	564	389	387	609	153	682	548	876	414
	Score 2	288	286	155	299	400	167	237	489	392	400	245	218	84	229	253	232	230	298	290	130	0	0	0	0
	Score 3	317	193	270	296	253	192	115	267	286	275	311	255	123	241	198	189	218	228	208	152	0	0	0	0
	Score 4	222	124	246	257	127	95	29	188	212	295	287	285	99	141	183	157	224	217	172	101	0	0	0	0
	Score 5	188	100	359	192	85	106	26	114	199	110	265	244	149	128	243	205	188	176	117	112	0	0	0	0
	Score 6	44	24	238	63	28	36	12	57	67	76	120	229	54	61	128	92	151	88	43	52	0	0	0	0
	Score 7	4	5	94	23	5	28	2	12	7	19	23	27	169	40	37	13	77	52	3	42	0	0	0	0
	Score 8	0	0	3	1	0	0	0	0	0	1	0	0	0	1	1	1	2	0	0	0	0	0	0	0
	Sample Size	*1492*	*1490*	*1478*	*1473*	*1468*	*785*	*1500*	*1481*	*1478*	*1476*	*1465*	*1454*	*733*	*1477*	*1456*	*1453*	*1459*	*1446*	*1442*	*742*	*682*	*548*	*876*	*414*

National Survey: Summary of Responses from Full Sample, Showing Doctors and Managers as Two Separate Groups

		3bM	3bC	3bT	3bN	3cM	3cC	3cT	3cN	4a	4b	4c	4d	4e	4f	4g	4h	4j	4k	4m	4n	5a	5b	6a	6b
	Sample Mean	1	1	1	1	1	1	1	1	2.509	2.5017	2.4368	2.5826	2.6117	2.5568	2.779	2.4863	2.4532	2.633	2.8021	2.5115	3.5027	42.959	3.5488	35.373
	Sample Standard Deviation	0	0	0	0	0	0	0	0	0.5769	0.5728	0.6615	0.5236	0.5335	0.6565	0.4746	0.6864	0.7495	0.6101	0.4804	0.7583	1.0149	23.376	0.8927	18.589
	Doctors Mean	1	1	1	1	1	1	1	1	2.4088	2.3966	2.3512	2.4685	2.4378	2.3494	2.8037	2.339	2.3323	2.5492	2.7249	2.3733	3.2389	44.81	3.321	36.702
	Doctors Standard Deviation	0	0	0	0	0	0	0	0	0.6042	0.5766	0.6518	0.538	0.5687	0.706	0.4585	0.7385	0.8008	0.6787	0.5661	0.8016	1.0572	25.109	0.951	17.902
	Managers Mean	1	1	1	1	1	1	1	1	2.5861	2.5826	2.503	2.6706	2.7464	2.7419	2.7602	2.5976	2.545	2.6967	2.8607	2.6162	3.7051	41.647	3.7225	34.41
	Managers Standard Deviation	0	0	0	0	0	0	0	0	0.543	0.5569	0.6618	0.4949	0.4619	0.5498	0.4859	0.6219	0.6946	0.544	0.394	0.7101	0.9324	21.987	0.8039	19.024
	Frequencies																								
Doctors	Score 1	246	222	326	216	216	265	316	198	40	30	64	13	25	11	17	103	136	69	39	15	36	0	9	0
	Score 2	0	0	0	0	0	0	0	0	305	331	295	320	316	32	94	219	162	155	100	17	143	0	160	0
	Score 3	0	0	0	0	0	0	0	0	306	287	293	318	310	40	541	321	352	428	508	43	157	0	131	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	263	0	315	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	54	0	36	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*246*	*222*	*326*	*216*	*216*	*265*	*316*	*198*	*651*	*648*	*652*	*651*	*651*	*83*	*652*	*643*	*650*	*650*	*647*	*75*	*653*	*0*	*651*	*0*
Managers	Score 1	478	395	628	120	426	485	600	89	22	28	79	10	10	5	23	62	100	38	15	13	14	0	9	1
	Score 2	0	0	0	0	0	0	0	0	307	295	261	258	193	14	160	218	189	187	89	12	104	0	87	0
	Score 3	0	0	0	0	0	0	0	0	519	518	503	576	637	74	678	570	566	631	750	74	136	1	112	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	462	0	570	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	135	0	76	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*478*	*395*	*628*	*120*	*426*	*485*	*600*	*89*	*648*	*641*	*643*	*844*	*840*	*93*	*859*	*850*	*855*	*854*	*854*	*99*	*851*	*1*	*854*	*1*
Total	Score 1	724	617	954	336	642	750	916	287	62	58	143	23	35	16	40	165	236	105	54	28	50	0	18	1
	Score 2	0	0	0	0	0	0	0	0	612	626	556	578	509	46	254	437	351	342	189	29	247	0	247	0
	Score 3	0	0	0	0	0	0	0	0	825	805	796	894	947	114	1217	891	918	1057	1258	117	293	1	243	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	725	0	885	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	189	0	112	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*724*	*617*	*954*	*336*	*642*	*750*	*916*	*287*	*1499*	*1489*	*1495*	*1495*	*1491*	*176*	*1511*	*1493*	*1505*	*1504*	*1501*	*174*	*1504*	*1*	*1505*	*1*

National Survey: Summary of Responses from Full Sample, Showing Doctors and Managers as Two Separate Groups

		Q7	8a_Con	8a_Nur	8a_Man	a_ChE	8a_TB	8a_Pur	8a_Oth	8b_Con	8b_Nur	8b_Ma	b_ChE	8b_TB	8b_Pur	8b_Oth	8c_Con	8c_Nur	8c_Man	c_ChE	8c_TB	8c_Pur	8c_Oth	8d_Con	8d_Nur
	Sample Mean	1.8001	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Sample Standard Deviation	0.8147	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Doctors Mean	1.79	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Doctors Standard Deviation	0.886	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Managers Mean	1.4544	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Managers Standard Deviation	0.7228	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Frequencies																								
Doctors	Score 1	331	216	10	74	89	63	283	23	38	19	283	130	78	162	17	166	3	109	148	128	145	61	8	122
	Score 2	137	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	188	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*657*	*216*	*10*	*74*	*89*	*63*	*283*	*23*	*38*	*19*	*283*	*130*	*78*	*162*	*17*	*166*	*3*	*109*	*148*	*128*	*145*	*61*	*8*	*122*
Managers	Score 1	583	265	35	139	105	90	372	29	148	51	378	79	126	151	23	370	4	115	145	157	127	59	12	203
	Score 2	156	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	114	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*654*	*265*	*35*	*139*	*105*	*90*	*372*	*29*	*148*	*51*	*378*	*79*	*126*	*151*	*23*	*370*	*4*	*115*	*145*	*157*	*127*	*59*	*12*	*203*
Total	Score 1	914	481	45	213	194	153	655	52	186	70	661	209	204	313	40	536	7	224	293	285	272	120	20	325
	Score 2	293	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	302	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*1511*	*481*	*45*	*213*	*194*	*153*	*655*	*52*	*186*	*70*	*661*	*209*	*204*	*313*	*40*	*536*	*7*	*224*	*293*	*285*	*272*	*120*	*20*	*325*

National Survey: Summary of Responses from Full Sample, Showing Doctors and Managers as Two Separate Groups

		8d_Ma	d_ChE	8d_TB	8d_Pur	8d_Oth	8e_Con	8e_Nur	8e_Man	e_ChE	8e_TB	8e_Pur	8e_Oth	8f_Con	8f_Nur	8f_Man	f_ChE	8f_TB	8f_Pur	8f_Oth	Q9	10a
	Sample Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1.9666	1.7762
	Sample Standard Deviation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.6013	0.8134
	Doctors Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1.8012	1.7139
	Doctors Standard Deviation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.6149	0.8385
	Managers Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2.0913	1.8235
	Managers Standard Deviation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.5598	0.791
	Frequencies																					
Doctors	Score 1	329	82	88	93	18	507	17	74	9	9	69	8	622	9	18	7	4	35	5	206	323
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	390	249
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	73	71
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*329*	*82*	*88*	*93*	*18*	*507*	*17*	*74*	*9*	*9*	*69*	*8*	*622*	*9*	*18*	*7*	*4*	*35*	*5*	*669*	*671*
Managers	Score 1	466	61	140	98	33	722	36	93	10	9	57	22	797	46	27	8	9	70	24	102	329
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	602	420
	Score 3	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	183	98
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	36
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*466*	*61*	*140*	*98*	*33*	*722*	*36*	*93*	*10*	*9*	*57*	*22*	*797*	*46*	*27*	*8*	*9*	*70*	*24*	*887*	*884*
Total	Score 1	795	143	228	191	51	1229	53	167	19	18	126	30	1419	55	45	15	13	105	29	308	652
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	992	669
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	256	169
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*795*	*143*	*228*	*191*	*51*	*1229*	*53*	*167*	*19*	*18*	*126*	*30*	*1419*	*55*	*45*	*15*	*13*	*105*	*29*	*1556*	*1555*

National Survey: Summary of Responses from Doctors' Sample, Showing Separate Categories of Doctors

		1a	1b	1c	1d	1e	1f	1g	1h	1j	2a	2b	2c	2d	2e	2f	2g	2h	2j	2k	2m	2n	2p	2q	2r	2s
	Total Doctor Mean	2.929	3.662	3.527	4.096	3.54	3.385	3.295	3.96	4.362	3.908	2.754	1.776	4.076	3.472	2.124	2.97	1.557	2.505	3.067	2.798	3.419	3.968	5.223	4.801	2.565
	Chair of Clinical Directorate Mean	2.958	3.705	3.542	4.134	3.58	3.395	3.388	3.973	4.371	3.723	2.755	1.714	4.065	3.464	2.149	3.083	1.542	2.425	2.902	2.878	3.399	3.906	5.076	4.688	2.605
	Board Director Mean	2.917	3.639	3.444	4.139	3.75	3.314	3.194	4.167	5	3.444	2.889	1.917	3.8	3.861	2.667	2.913	1.571	1.943	2.743	3.486	3.771	4	4.9	4.857	2.771
	Consultant Only Mean	2.901	3.819	3.521	4.051	3.475	3.382	3.208	3.923	4.333	4.15	2.737	1.822	4.118	3.433	2.033	2.856	1.571	2.653	3.273	2.639	3.398	4.027	5.413	4.48	2.498
	Frequencies																									
Chair	Score 1	30	8	7	4	5	10	17	6	1	25	98	200	37	60	130	46	205	79	65	64	50	28	7	8	106
	Score 2	83	28	28	1	18	43	54	16	0	44	55	58	29	39	82	37	54	98	67	75	42	36	9	17	46
	Score 3	112	83	105	50	114	109	95	56	3	83	59	18	42	60	46	40	41	74	72	63	65	61	22	49	67
	Score 4	81	145	159	166	165	141	112	153	12	62	45	17	65	55	30	25	8	35	46	67	62	51	16	53	47
	Score 5	24	64	31	108	27	26	52	97	19	52	34	14	56	46	11	24	2	15	47	15	57	58	46	81	31
	Score 6	0	1	0	0	0	0	0	0	0	27	14	3	57	30	8	8	0	5	9	20	21	61	16	65	8
	Score 7	0	0	0	0	0	0	0	0	0	18	5	1	19	16	1	12	0	0	0	2	6	3	56	34	1
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*330*	*329*	*330*	*329*	*329*	*329*	*330*	*328*	*35*	*311*	*310*	*311*	*306*	*306*	*308*	*192*	*310*	*306*	*306*	*306*	*303*	*298*	*172*	*307*	*306*
Board	Score 1	1	1	1	0	0	2	1	0	0	4	11	19	5	6	12	6	23	13	6	3	4	3	1	1	7
	Score 2	11	2	5	1	2	4	8	1	0	5	7	10	3	2	7	4	6	16	10	6	5	4	1	0	6
	Score 3	14	9	12	3	8	12	15	5	0	8	4	3	9	5	6	7	4	2	11	9	5	4	1	3	13
	Score 4	10	21	13	22	23	15	7	17	0	13	7	0	8	11	8	1	2	3	4	9	7	10	5	8	6
	Score 5	0	3	5	10	3	2	5	13	1	3	4	3	4	5	2	3	0	1	3	4	9	8	5	12	3
	Score 6	0	0	0	0	0	0	0	0	0	2	2	1	5	4	3	1	0	0	1	4	5	5	2	9	0
	Score 7	0	0	0	0	0	0	0	0	0	1	1	0	3	3	0	1	0	0	0	0	0	1	5	2	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*36*	*36*	*36*	*36*	*36*	*35*	*36*	*36*	*1*	*36*	*36*	*36*	*35*	*36*	*36*	*23*	*35*	*35*	*35*	*35*	*35*	*35*	*20*	*35*	*35*
Consultant	Score 1	34	9	6	4	6	12	24	4	1	16	85	185	30	57	143	59	208	71	46	68	45	30	5	7	93
	Score 2	64	24	36	18	35	40	68	20	0	33	65	52	40	53	75	22	37	82	48	94	42	29	5	17	70
	Score 3	132	90	98	43	108	121	86	60	3	49	57	32	37	50	37	46	44	74	73	61	64	50	16	56	61
	Score 4	63	147	135	143	138	98	89	139	12	81	46	14	57	57	22	19	10	37	53	44	62	55	16	69	41
	Score 5	19	45	38	107	29	43	48	88	17	67	33	15	61	31	16	17	2	26	71	20	61	55	40	65	18
	Score 6	0	0	0	0	0	0	0	0	0	38	12	4	55	23	6	11	2	9	9	10	15	71	18	53	8
	Score 7	0	0	0	0	0	0	0	0	0	22	2	2	24	27	0	7	0	1	0	2	5	3	67	27	2
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*312*	*315*	*313*	*315*	*314*	*314*	*313*	*311*	*33*	*306*	*300*	*304*	*304*	*298*	*299*	*181*	*303*	*300*	*300*	*299*	*294*	*293*	*167*	*294*	*293*
	Total Standard Deviation	1.046	0.939	0.892	0.829	0.825	0.957	1.126	0.908	0.874	1.579	1.588	1.264	1.779	1.832	1.341	1.783	0.919	1.297	1.451	1.445	1.571	1.635	1.726	1.498	1.444
	Chair of Clinical Directorate S.D.	1.074	0.967	0.857	0.765	0.78	0.918	1.092	0.91	0.877	1.588	1.624	1.218	1.775	1.791	1.328	1.779	0.865	1.218	1.448	1.477	1.595	1.624	1.77	1.538	1.494
	Board Director S.D.	0.841	0.833	0.998	0.683	0.692	0.963	1.037	0.775		1.443	1.753	1.36	1.844	1.807	1.621	1.73	0.917	1.027	1.291	1.442	1.61	1.572	1.714	1.24	1.215
	Consultant Only S.D.	1.039	0.921	0.917	0.905	0.88	0.999	1.165	0.92	0.89	1.552	1.532	1.3	1.78	1.876	1.305	1.752	0.974	1.378	1.449	1.387	1.542	1.657	1.669	1.477	1.416

National Survey: Summary of Responses from Doctors' Sample, Showing Separate Categories of Doctors

		2t	2u	2v	2w	2x	2y	2z	2aa	2ab	2ac	2ad	2ae	2af	2ag	2ah	2aj	2ak	2am	2an	3aM	3aC	3aT	3aN	3bM	3bC
	Total Doctor Mean	1.756	4.245	3.154	2.126	3.283	1.479	2.648	3.107	2.766	3.459	3.939	4.814	2.911	3.175	2.609	3.316	3.025	2.265	3.382	1	1	1	1	1	1
	Chair of Clinical Directorate Mean	1.693	4.397	3.15	2.237	3.19	1.462	2.588	2.99	2.83	3.507	3.936	4.684	2.733	3.189	2.635	3.246	3.007	2.297	3.483	1	1	1	1	1	1
	Board Director Mean	1.943	4.143	3.171	2	2.955	1.286	2.371	2.857	3.057	3.829	3.857	4.091	2.886	3.441	2.824	3.229	3.343	2.457	2.836	1	1	1	1	1	1
	Consultant Only Mean	1.799	4.1	3.157	2.024	3.379	1.516	2.743	3.281	2.867	3.364	3.951	5.049	3.096	3.129	2.556	3.398	3.004	2.208	3.376	1	1	1	1	1	1
	Frequencies																									
Chair	Score 1	199	23	50	112	33	222	71	53	58	38	27	9	109	74	118	90	82	124	27	115	120	159	113	124	118
	Score 2	47	30	51	87	34	51	102	84	89	42	33	18	42	56	46	31	54	62	34	0	0	0	0	0	0
	Score 3	28	42	73	59	49	17	59	57	50	75	80	26	59	40	45	45	49	47	34	0	0	0	0	0	0
	Score 4	14	43	70	25	22	7	33	42	66	52	56	23	34	41	26	43	45	32	25	0	0	0	0	0	0
	Score 5	10	80	47	12	31	6	23	42	21	60	58	40	35	49	39	40	33	23	23	0	0	0	0	0	0
	Score 6	5	55	8	6	9	1	11	19	12	27	56	6	8	27	18	32	19	8	16	0	0	0	0	0	0
	Score 7	0	27	2	3	6	1	2	1	2	4	6	52	13	10	4	15	13	0	13	0	0	0	0	0	0
	Score 8	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	Sample Size	*303*	*301*	*301*	*304*	*184*	*305*	*301*	*298*	*300*	*298*	*296*	*174*	*300*	*297*	*296*	*297*	*295*	*296*	*172*	*115*	*120*	*159*	*113*	*124*	*118*
Board	Score 1	20	2	8	18	4	26	8	8	5	6	4	2	9	6	11	10	9	15	4	19	12	16	10	18	15
	Score 2	5	4	5	7	4	4	15	9	10	2	4	1	8	6	7	2	5	8	10	0	0	0	0	0	0
	Score 3	6	5	8	5	9	3	8	9	8	5	5	6	6	7	6	8	6	0	2	0	0	0	0	0	0
	Score 4	2	6	5	1	1	0	1	8	6	8	10	5	6	2	1	7	5	6	3	0	0	0	0	0	0
	Score 5	0	14	6	2	3	0	1	2	3	9	5	4	2	9	7	4	3	5	2	0	0	0	0	0	0
	Score 6	2	2	2	0	0	0	2	1	2	3	6	0	4	3	1	1	4	1	1	0	0	0	0	0	0
	Score 7	0	2	1	1	1	0	0	0	1	2	1	4	0	1	0	3	3	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	Sample Size	*35*	*35*	*35*	*34*	*22*	*35*	*35*	*35*	*35*	*35*	*35*	*22*	*35*	*34*	*34*	*35*	*35*	*35*	*22*	*19*	*12*	*16*	*10*	*18*	*15*
Consultant	Score 1	172	27	53	129	30	209	52	40	65	46	34	4	88	72	118	83	82	136	33	102	89	126	121	104	89
	Score 2	58	34	63	76	32	55	94	54	100	41	37	11	43	42	39	42	48	48	19	0	0	0	0	0	0
	Score 3	29	52	52	44	36	21	65	62	49	62	36	27	48	64	45	32	45	42	44	0	0	0	0	0	0
	Score 4	21	46	60	29	23	3	51	68	48	62	59	18	34	34	35	31	45	32	28	0	0	0	0	0	0
	Score 5	10	57	32	7	34	6	21	56	17	55	52	32	37	43	35	36	31	16	27	0	0	0	0	0	0
	Score 6	3	52	15	2	9	5	6	12	10	15	61	15	25	22	13	40	14	9	9	0	0	0	0	0	0
	Score 7	0	23	10	1	10	0	3	0	5	5	8	57	16	8	1	25	16	1	10	0	0	0	0	0	0
	Score 8	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*293*	*291*	*286*	*288*	*174*	*299*	*292*	*292*	*294*	*286*	*287*	*164*	*291*	*286*	*286*	*289*	*281*	*284*	*170*	*102*	*89*	*126*	*121*	*104*	*89*
	Total Standard Deviation	1.195	1.842	1.544	1.277	1.675	0.966	1.368	1.478	1.442	1.565	1.67	1.868	1.824	1.789	1.694	2.015	1.814	1.461	1.766	0	0	0	0	0	0
	Chair of Clinical Directorate S.D.	1.186	1.943	1.422	1.328	1.623	0.949	1.403	1.527	1.422	1.553	1.615	1.908	1.745	1.821	1.734	1.953	1.786	1.435	1.827	0	0	0	0	0	0
	Board Director S.D.	1.392	1.517	1.706	1.458	1.527	0.822	1.285	1.327	1.552	1.757	1.665	1.797	1.659	1.779	1.85	1.88	2.014	1.651	1.432	0	0	0	0	0	0
	Consultant Only S.D.	1.187	1.762	1.65	1.194	1.745	1.014	1.336	1.425	1.447	1.549	1.731	1.806	1.908	1.759	1.636	2.094	1.82	1.464	1.727	0	0	0	0	0	0

National Survey: Summary of Responses from Doctors' Sample, Showing Separate Categories of Doctors

		3bT	3bN	3cM	3cC	3cT	3cN	4a	4b	4c	4d	4e	4f	4g	4h	4j	4k	4m	4n	5a	5b	6a	6b	Q7	a_Co	8a_Nu
	Total Doctor Mean	1	1	1	1	1	1	2.409	2.397	2.351	2.469	2.438	2.349	2.804	2.339	2.332	2.549	2.725	2.373	3.239	44.81	3.321	36.7	1.79	1	1
	Chair of Clinical Directorate Mean	1	1	1	1	1	1	2.456	2.43	2.356	2.491	2.444	2.364	2.761	2.344	2.351	2.601	2.722	2.333	3.364	44.59	3.442	36.04	1.693	1	1
	Board Director Mean	1	1	1	1	1	1	2.6	2.324	2.4	2.571	2.514	2.6	2.853	2.424	2.471	2.647	2.824	2.2	3.657	45.24	3.382	35.42	1.543	1	
	Consultant Only Mean	1	1	1	1	1	1	2.334	2.369	2.34	2.432	2.422	2.311	2.845	2.324	2.296	2.481	2.717	2.441	3.057	44.98	3.182	37.62	1.921	1	1
	Frequencies																									
Chair	Score 1	166	102	112	143	167	89	21	14	39	8	12	4	11	47	85	26	17	8	10	0	4	0	175	108	6
	Score 2	0	0	0	0	0	0	132	155	128	148	155	13	55	116	79	77	55	8	58	0	66	0	67	0	0
	Score 3	0	0	0	0	0	0	167	152	153	186	155	16	256	157	178	220	248	20	84	0	56	0	77	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	140	0	174	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27	0	21	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*166*	*102*	*112*	*143*	*167*	*89*	*320*	*321*	*320*	*322*	*322*	*33*	*322*	*320*	*322*	*323*	*320*	*36*	*319*	*0*	*321*	*0*	*319*	*108*	*6*
Board	Score 1	19	6	16	16	19	6	0	2	2	0	1	0	0	2	4	1	1	1	1	0	0	0	23	12	0
	Score 2	0	0	0	0	0	0	14	19	17	15	15	2	5	15	10	10	4	2	5	0	8	0	5	0	0
	Score 3	0	0	0	0	0	0	21	13	16	20	19	3	29	16	20	23	29	2	5	0	7	0	7	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	17	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	2	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*19*	*6*	*16*	*16*	*19*	*6*	*35*	*34*	*35*	*35*	*35*	*5*	*34*	*33*	*34*	*34*	*34*	*5*	*35*	*0*	*34*	*0*	*35*	*12*	*0*
Consultant	Score 1	141	108	86	106	130	103	19	14	23	5	12	7	6	54	67	42	21	6	25	0	5	0	133	96	4
	Score 2	0	0	0	0	0	0	159	157	150	157	146	17	34	88	73	68	41	7	80	0	86	0	65	0	0
	Score 3	0	0	0	0	0	0	118	122	124	132	136	21	256	148	154	183	231	21	68	0	68	0	104	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	105	0	124	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21	0	13	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*141*	*108*	*86*	*106*	*130*	*103*	*296*	*293*	*297*	*294*	*294*	*45*	*296*	*290*	*294*	*293*	*293*	*34*	*299*	*0*	*296*	*0*	*303*	*96*	*4*
	Total Standard Deviation	0	0	0	0	0	0	0.604	0.577	0.652	0.538	0.569	0.706	0.459	0.738	0.801	0.679	0.566	0.802	1.057	25.11	0.951	17.9	0.886	0	0
	Chair of Clinical Directorate S.D.	0	0	0	0	0	0	0.617	0.577	0.669	0.548	0.568	0.699	0.501	0.722	0.796	0.634	0.555	0.828	0.977	25.19	0.931	17.65	0.835	0	0
	Board Director S.D.	0	0	0	0	0	0	0.497	0.589	0.604	0.502	0.562	0.548	0.359	0.614	0.706	0.544	0.459	0.837	1.027	19.02	0.922	19.62	0.817	0	
	Consultant Only S.D.	0	0	0	0	0	0	0.593	0.574	0.617	0.529	0.572	0.733	0.415	0.77	0.816	0.734	0.59	0.786	1.111	25.8	0.96	17.98	0.928	0	0

National Survey: Summary of Responses from Doctors' Sample, Showing Separate Categories of Doctors

		a_Ma	a_ChE	8a_TB	8a_Pu	8a_Ot	b_Co	8b_Nu	b_Ma	b_ChE	8b_TB	8b_Pu	8b_Ot	c_Co	8c_Nu	c_Ma	c_ChE	8c_TB	8c_Pu	8c_Ot	d_Co	8d_Nu	d_Ma	d_ChE	8d_TB	8d_Pu
	Total Doctor Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Chair of Clinical Directorate Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Board Director Mean	1	1	1	1		1	1	1	1		1		1		1	1		1		1	1	1	1	1	1
	Consultant Only Mean	1	1	1	1		1	1	1	1	1	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Frequencies																									
Chair	Score 1	35	47	27	130	13	14	7	130	67	42	79	9	92	1	40	65	61	76	30	4	62	153	38	47	46
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*35*	*47*	*27*	*130*	*13*	*14*	*7*	*130*	*67*	*42*	*79*	*9*	*92*	*1*	*40*	*65*	*81*	*76*	*30*	*4*	*62*	*153*	*38*	*47*	*46*
Board	Score 1	3	2	3	18	1	3	1	19	5	0	8	2	10	0	3	7	0	5	12	1	8	19	3	2	4
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*3*	*2*	*3*	*18*	*1*	*3*	*1*	*19*	*5*	*0*	*8*	*2*	*10*	*0*	*3*	*7*	*0*	*5*	*12*	*1*	*8*	*19*	*3*	*2*	*4*
Consultant	Score 1	36	40	33	135	9	21	11	134	58	36	75	6	64	2	66	76	67	64	19	3	52	157	41	39	43
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*36*	*40*	*33*	*135*	*9*	*21*	*11*	*134*	*58*	*36*	*75*	*6*	*64*	*2*	*66*	*76*	*67*	*64*	*19*	*3*	*52*	*157*	*41*	*39*	*43*
	Total Standard Deviation	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0
	Chair of Clinical Directorate S.D.	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0
	Board Director S.D.	0	0	0	0		0		0	0		0		0		0	0		0			0	0	0	0	0
	Consultant Only S.D.	0	0	0	0		0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0

National Survey: Summary of Responses from Doctors' Sample, Showing Separate Categories of Doctors

		8d_Ot	e_Co	8e_Nu	e_Ma	e_ChE	8e_TB	8e_Pu	8e_Ot	8f_Co	8f_Nur	8f_Ma	f_ChE	8f_TB	8f_Pur	8f_Oth	Q9	10a	10b	10c
	Total Doctor Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1.801	1.714	56.78	66.32
	Chair of Clinical Directorate Mean		1	1	1	1	1	1	1	1	1	1	1	1	1		1.815	1.689	58.26	69.29
	Board Director Mean		1	1	1			1		1	1				1		2.056	2	36.67	75
	Consultant Only Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1.756	1.706	56.58	62.5
	Frequencies																			
Chair	Score 1	11	256	8	37	5	3	25	4	302	5	10	4	2	14	3	105	156	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	175	127	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	45	29	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*11*	*256*	*8*	*37*	*5*	*3*	*25*	*4*	*302*	*5*	*10*	*4*	*2*	*14*	*3*	*325*	*325*	*0*	*0*
Board	Score 1	0	30	1	5	0	0	2	0	32	1	0	0	0	3	0	6	13	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22	15	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	4	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*0*	*30*	*1*	*5*	*0*	*0*	*2*	*0*	*32*	*1*	*0*	*0*	*0*	*3*	*0*	*36*	*36*	*0*	*0*
Consultant	Score 1	7	221	8	32	4	6	42	4	288	3	8	3	2	18	2	95	154	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	193	107	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20	38	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*7*	*221*	*8*	*32*	*4*	*6*	*42*	*4*	*288*	*3*	*8*	*3*	*2*	*18*	*2*	*308*	*310*	*0*	*0*
	Total Standard Deviation		0	0	0	0	0	0	0	0	0	0	0	0	0		0.615	0.838	36.81	31.74
	Chair of Clinical Directorate S.D.		0	0	0	0	0	0		0	0	0	0	0	0		0.655	0.797	37.02	33.16
	Board Director S.D.		0		0			0		0					0		0.63	1.042	46.19	30
	Consultant Only S.D.		0	0	0	0	0	0		0	0	0	0	0	0		0.561	0.852	36.49	32.1

National Survey: Summary of Responses Showing Separate Categories of Managers

		1a	1b	1c	1d	1e	1f	1g	1h	1j	2a	2b	2c	2d	2e	2f	2g	2h
	Chair Mean	4	4.2	3.8	4.4	4	3.6	4	4.2	5	2.8	2.6	2.4	4.2	4.25	3.75	3.667	2.8
	CEO Mean	4.329	3.961	2.902	4.384	4.178	3.087	3.958	4.268	4.333	1.616	3.014	2.548	3.764	3.708	2.812	3.618	2.014
	Board Director Mean	4.068	4.326	3.426	4.264	3.773	2.861	4.118	4.139	4.462	1.873	2.631	2.39	3.276	3.321	2.866	3.653	2.307
	Corporate Mean	3.8	4.273	3.175	4.323	3.605	2.636	4.023	3.85	4.227	2.062	2.791	2.836	3.488	3.643	3.039	3.418	2.299
	Clinical Mean	3.413	4.113	3.59	4.075	3.413	2.873	3.675	4.139	4.444	2.769	2.571	2.038	3.803	3.545	2.716	3.22	1.974
	Service Mean	3.645	4.174	3.373	4.279	3.631	2.839	4.006	4.103	4.279	2.035	2.413	2.064	3.352	3.356	2.625	3.476	1.88
	Other/Unknown Mean	3.544	4.176	3.09	4.224	3.552	2.773	3.706	3.821	4.4	2.062	2.492	2.234	3.692	3.25	2.857	2.926	2
	Total Managers Mean	3.802	4.209	3.324	4.269	3.684	2.837	3.98	4.071	4.339	2.037	2.593	2.281	3.457	3.433	2.792	3.459	2.08
	Frequencies																	
CEO	Score 1	0	1	5	0	0	2	3	0	0	46	22	26	8	15	19	3	32
	Score 2	0	4	17	0	1	17	5	3	0	13	14	17	9	7	14	9	18
	Score 3	6	8	21	4	11	28	11	4	0	11	7	10	14	13	14	4	13
	Score 4	37	21	15	37	35	17	26	35	6	2	10	9	16	8	10	7	7
	Score 5	30	17	3	32	26	5	27	29	3	1	13	7	16	12	7	6	2
	Score 6	0	0	0	0	0	0	0	0	0	0	5	3	5	12	5	3	0
	Score 7	0	0	0	0	0	0	0	0	0	0	2	1	3	5	0	2	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Sample Size	*73*	*51*	*61*	*73*	*73*	*69*	*72*	*71*	*9*	*73*	*73*	*73*	*72*	*72*	*69*	*34*	*72*
Board Dir	Score 1	0	1	6	1	1	26	3	2	2	129	55	76	37	28	60	22	94
	Score 2	8	2	31	1	6	54	6	12	0	26	68	60	39	48	43	15	31
	Score 3	38	10	78	13	67	73	40	31	0	35	35	32	42	45	35	11	39
	Score 4	104	115	67	129	114	54	84	80	6	9	25	20	46	34	28	6	32
	Score 5	69	87	34	76	32	11	87	91	18	8	20	15	28	34	23	20	9
	Score 6	0	0	0	0	0	0	0	0	0	5	10	8	18	22	19	9	8
	Score 7	0	0	0	0	0	0	0	0	0	1	1	2	4	1	1	12	1
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*219*	*215*	*216*	*220*	*220*	*218*	*220*	*216*	*26*	*213*	*214*	*213*	*214*	*212*	*209*	*95*	*212*
Corporate	Score 1	1	0	5	0	0	16	1	3	1	66	28	40	10	10	29	19	54
	Score 2	9	1	25	3	9	46	5	9	0	24	35	39	33	24	27	7	23
	Score 3	32	11	52	8	49	42	27	28	3	17	31	12	27	29	20	6	27
	Score 4	61	68	31	63	55	19	53	51	7	14	12	13	29	28	25	5	14
	Score 5	27	48	13	56	16	6	43	36	11	7	17	16	9	19	18	2	4
	Score 6	0	0	0	0	0	0	0	0	0	2	6	9	15	15	7	8	4
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	6	4	2	9	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	Sample Size	*130*	*128*	*126*	*130*	*129*	*129*	*129*	*127*	*22*	*130*	*129*	*129*	*129*	*129*	*128*	*55*	*126*
Clinical	Score 1	2	1	2	0	0	3	2	0	0	16	31	47	11	13	25	11	36
	Score 2	7	0	4	0	7	27	7	3	0	17	14	10	6	11	11	4	19
	Score 3	30	7	30	12	36	31	25	11	1	25	9	6	16	18	13	9	13
	Score 4	38	53	30	50	34	13	27	37	3	12	9	7	11	10	14	6	6
	Score 5	3	19	12	18	3	5	19	28	5	5	10	4	20	11	7	7	3
	Score 6	0	0	0	0	0	0	0	0	0	3	2	2	10	9	4	1	0
	Score 7	0	0	0	0	0	0	0	0	0	0	2	2	2	5	0	3	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*90*	*80*	*78*	*80*	*80*	*79*	*80*	*79*	*9*	*78*	*77*	*78*	*76*	*77*	*74*	*41*	*77*
Service	Score 1	3	2	11	1	2	23	4	6	0	136	114	148	44	60	111	29	161
	Score 2	23	2	42	7	17	94	11	10	2	76	78	78	61	53	49	22	65
	Score 3	92	38	105	27	108	118	61	39	2	68	50	36	65	58	49	16	53
	Score 4	159	171	126	148	155	62	140	148	21	18	31	24	60	41	47	17	23
	Score 5	36	103	27	132	32	14	97	109	18	9	21	17	39	49	36	14	3
	Score 6	0	0	0	0	0	0	0	0	0	4	13	7	33	37	10	10	4
	Score 7	0	0	0	0	0	0	0	0	0	0	3	1	5	8	2	16	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*313*	*316*	*311*	*315*	*314*	*311*	*313*	*312*	*43*	*311*	*310*	*311*	*307*	*306*	*304*	*124*	*309*
Other/Unidentified	Score 1	1	1	9	1	2	10	2	4	0	34	17	21	5	11	20	8	31
	Score 2	4	1	11	0	3	18	3	5	0	13	22	20	13	13	10	5	18
	Score 3	26	5	18	6	26	18	20	7	1	8	12	14	12	14	8	5	2
	Score 4	31	39	23	36	28	17	31	34	1	3	7	6	16	11	12	2	7
	Score 5	6	22	6	24	8	3	12	17	3	4	6	2	7	8	10	5	5
	Score 6	0	0	0	0	0	0	0	0	0	3	0	1	10	4	3	1	0
	Score 7	0	0	0	0	0	0	0	0	0	0	1	0	2	3	0	1	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*68*	*68*	*67*	*67*	*67*	*66*	*68*	*67*	*5*	*65*	*65*	*64*	*65*	*64*	*63*	*27*	*63*
	Chair Standard Deviation	1.225	0.837	1.304	0.894	1	1.517	1	0.837		2.168	1.14	1.517	2.588	1.258	1.708	1.528	1.483
	CEO S.D.	0.625	0.999	1.028	0.592	0.733	0.951	1.093	0.755	0.5	0.937	1.629	1.606	1.666	1.968	1.584	1.724	1.132
	Board Director S.D.	0.796	0.653	1.009	0.629	0.742	1.075	0.894	0.925	1.104	1.327	1.485	1.487	1.614	1.573	1.679	2.118	1.449
	Corporate S.D.	0.875	0.649	0.997	0.896	0.795	1.03	0.879	0.993	1.02	1.345	1.467	1.63	1.626	1.585	1.624	2.394	1.56
	Clinical S.D.	0.807	0.656	0.904	0.812	0.706	0.952	1.016	0.796	0.726	1.328	1.712	1.607	1.689	1.832	1.583	1.851	1.147
	Service S.D.	0.816	0.707	0.945	0.739	0.765	0.977	0.873	0.876	0.766	1.165	1.513	1.354	1.609	1.767	1.587	2.074	1.129
	Other/Unknown S.D.	0.8	0.752	1.19	0.735	0.875	1.134	0.915	1.086	0.894	1.467	1.371	1.192	1.619	1.69	1.645	1.796	1.308
	Total Managers S.D.	0.845	0.71	1.006	0.686	0.785	1.025	0.924	0.914	0.877	1.287	1.541	1.478	1.637	1.71	1.622	2.056	1.309

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		2j	2k	2m	2n	2p	2q	2r	2s	2t	2u	2v	2w	2x	2y	2z	2aa	2ab
	Chair Mean	3.2	2.6	3.2	4.25	3.75	4	5	2.6	2.6	4.4	3.75	3	3	2.2	2.8	2.6	3.8
	CEO Mean	2.408	2.521	3.543	3.7	3.536	4.719	4.657	2.629	2.386	4.357	2.577	2.29	2.795	1.87	2.75	2.5	3.676
	Board Director Mean	2.299	2.443	3.157	3.129	3.234	4.31	4.448	2.737	2.208	4	2.629	2.236	2.969	1.654	2.411	2.575	3.156
	Corporate Mean	2.44	2.563	3.236	3.325	3.143	4.804	4.609	2.85	2.598	4	2.69	2.181	2.679	1.367	2.78	2.953	2.938
	Clinical Mean	2.532	2.844	3.028	3.342	3.885	4.919	4.75	3.125	2.329	4.056	3.187	2.343	2.975	1.447	2.697	3.092	2.56
	Service Mean	2.326	2.407	3.155	3.224	3.114	4.458	4.484	2.642	2.226	4.141	2.856	2.352	2.865	1.352	2.433	2.697	2.757
	Other/Unknown Mean	2.429	2.349	3.111	3.113	3.197	4.542	4.561	2.787	2.226	3.967	2.705	2.383	2.552	1.484	2.429	2.46	3.065
	Total Managers Mean	2.374	2.484	3.185	3.262	3.241	4.545	4.54	2.762	2.3	4.085	2.821	2.297	2.847	1.492	2.53	2.707	2.966
	Frequencies																	
CEO	Score 1	24	21	10	11	9	2	1	18	28	4	25	28	12	33	16	18	9
	Score 2	19	20	14	8	11	0	4	13	18	6	14	16	5	16	19	21	8
	Score 3	13	13	8	8	12	6	9	16	7	12	12	12	9	13	14	16	13
	Score 4	7	10	20	18	15	5	10	12	7	14	10	7	9	4	8	5	18
	Score 5	6	3	6	15	15	8	31	8	8	15	7	2	1	1	7	7	10
	Score 6	2	4	9	9	7	6	11	3	0	12	2	4	2	0	4	0	7
	Score 7	0	0	2	1	0	5	3	0	2	6	1	0	1	0	0	1	2
	Score 8	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	1
	Sample Size	*71*	*71*	*70*	*70*	*69*	*32*	*70*	*70*	*70*	*70*	*71*	*69*	*39*	*69*	*68*	*68*	*68*
Board Dir	Score 1	80	67	32	27	31	9	7	65	98	16	54	77	23	137	64	58	29
	Score 2	58	59	45	59	51	11	13	43	47	20	47	63	18	33	71	64	49
	Score 3	30	41	48	46	37	12	40	36	24	48	41	36	27	29	31	32	44
	Score 4	21	17	51	29	37	11	39	29	15	38	30	12	12	5	18	20	47
	Score 5	17	20	13	33	24	19	59	32	25	50	29	14	8	4	15	27	16
	Score 6	5	5	19	15	24	6	39	8	2	25	9	6	3	2	9	6	16
	Score 7	0	1	2	0	1	19	15	0	1	12	1	0	6	1	1	0	2
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*211*	*210*	*210*	*209*	*205*	*87*	*212*	*213*	*212*	*209*	*211*	*208*	*97*	*211*	*207*	*207*	*205*
Corporate	Score 1	43	35	22	12	22	4	4	37	48	9	30	47	16	103	23	27	27
	Score 2	35	40	29	31	25	6	5	23	22	17	35	37	13	13	51	35	36
	Score 3	17	19	24	27	26	4	25	18	19	29	30	25	6	6	16	23	22
	Score 4	13	15	24	28	26	5	18	26	18	17	13	10	10	3	14	13	20
	Score 5	14	12	7	17	20	9	38	17	13	26	14	7	7	2	15	18	10
	Score 6	2	4	19	10	7	9	27	6	5	26	1	1	1	1	7	10	10
	Score 7	1	1	2	1	0	14	11	0	2	4	3	0	1	0	1	1	3
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*125*	*126*	*127*	*126*	*126*	*51*	*128*	*127*	*127*	*128*	*126*	*127*	*56*	*128*	*127*	*127*	*126*
Clinical	Score 1	19	21	12	14	12	1	0	14	32	6	17	29	6	55	22	15	20
	Score 2	25	16	16	9	8	5	3	14	12	5	12	12	10	13	18	17	22
	Score 3	19	11	22	18	11	2	10	13	13	13	13	14	12	6	13	12	16
	Score 4	4	16	17	15	15	4	15	16	8	17	9	7	5	0	13	16	8
	Score 5	7	10	3	12	14	11	26	13	5	20	14	7	5	1	5	12	6
	Score 6	3	2	5	8	13	4	10	2	3	6	7	1	2	1	4	2	3
	Score 7	0	1	1	0	0	10	8	1	0	3	0	0	0	0	1	2	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*77*	*77*	*76*	*76*	*73*	*37*	*72*	*72*	*73*	*72*	*72*	*70*	*40*	*76*	*76*	*76*	*75*
Service	Score 1	103	100	39	45	53	7	8	88	133	23	85	107	29	246	97	77	72
	Score 2	95	92	73	70	62	17	18	62	60	29	61	84	39	38	94	85	76
	Score 3	53	51	72	65	52	21	54	61	59	56	54	48	36	14	56	62	60
	Score 4	28	26	70	51	50	9	57	37	33	53	50	33	11	6	26	37	63
	Score 5	19	30	24	43	46	23	102	36	22	81	36	28	14	5	18	31	20
	Score 6	6	6	24	25	24	17	51	6	3	48	15	4	9	1	12	13	9
	Score 7	1	0	2	4	2	23	20	0	0	15	5	0	3	0	4	2	4
	Score 8	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0
	Sample Size	*307*	*307*	*304*	*303*	*299*	*118*	*310*	*310*	*310*	*306*	*306*	*304*	*141*	*310*	*307*	*307*	*304*
Other/Unidentified	Score 1	23	26	10	5	8	1	1	19	27	3	19	22	5	43	20	18	14
	Score 2	14	14	16	17	14	1	3	10	14	10	11	17	11	11	23	20	10
	Score 3	12	8	12	19	18	5	12	11	8	12	13	9	8	6	5	13	12
	Score 4	6	8	14	11	7	4	10	9	6	10	8	3	2	1	5	5	16
	Score 5	6	4	5	7	7	7	20	10	7	15	7	6	3	1	8	4	4
	Score 6	2	3	5	3	7	2	11	2	0	9	3	3	0	0	2	3	6
	Score 7	0	0	1	0	0	4	5	0	0	2	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*63*	*63*	*63*	*62*	*61*	*24*	*62*	*61*	*62*	*61*	*61*	*60*	*29*	*62*	*63*	*63*	*62*
	Chair Standard Deviation	2.168	1.949	2.168	0.5	1.708	1.732	1.225	2.074	1.949	1.14	2.062	2.16	2.646	2.168	1.643	1.949	1.924
	CEO S.D.	1.41	1.443	1.767	1.871	1.558	1.651	1.328	1.494	1.591	1.686	1.574	1.456	1.609	1.013	1.5	1.366	1.688
	Board Director S.D.	1.394	1.417	1.506	1.486	1.61	1.996	1.48	1.562	1.468	1.596	1.543	1.34	1.696	1.099	1.442	1.462	1.493
	Corporate S.D.	1.478	1.472	1.702	1.463	1.495	2.01	1.481	1.584	1.644	1.646	1.487	1.218	1.608	0.904	1.517	1.627	1.64
	Clinical S.D.	1.373	1.573	1.433	1.596	1.707	1.601	1.297	1.547	1.501	1.528	1.703	1.433	1.405	0.915	1.566	1.593	1.407
	Service S.D.	1.352	1.403	1.448	1.572	1.63	1.942	1.407	1.404	1.339	1.616	1.623	1.366	1.578	0.834	1.461	1.485	1.447
	Other/Unknown S.D.	1.467	1.515	1.557	1.294	1.536	1.641	1.409	1.582	1.396	1.57	1.553	1.519	1.183	0.864	1.489	1.401	1.577
	Total Managers S.D.	1.4	1.448	1.54	1.529	1.605	1.903	1.42	1.508	1.463	1.607	1.583	1.364	1.575	0.962	1.483	1.505	1.54

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		2ac	2ad	2ae	2af	2ag	2ah	2aj	2ak	2am	2an	3aM	3aC	3aT	3aN	3bM	3bC	3bT
	Chair Mean	4.5	4	4	3.4	2.4	2.8	3.8	3	3	3.667	1	1	1	1	1	1	1
	CEO Mean	4.203	3.735	4.061	2.515	3.818	3.212	3.818	3.394	2.537	3.152	1	1	1	1	1	1	1
	Board Director Mean	3.371	3.322	4.033	2.157	2.757	2.402	3.255	3.073	2.624	3.191	1	1	1	1	1	1	1
	Corporate Mean	3.126	3.339	3.759	2.04	3.185	3.016	2.992	2.734	2.236	2.982	1	1	1	1	1	1	1
	Clinical Mean	3.373	3.63	4.308	2.653	3.56	3.092	3.243	3	2.055	3.25	1	1	1	1	1	1	1
	Service Mean	3.26	3.475	4.142	2.056	2.87	2.69	2.953	2.873	2.309	3.323	1	1	1	1	1	1	1
	Other/Unknown Mean	3.387	3.443	3.731	2.079	2.857	2.587	3.222	2.742	2.45	2.963	1	1	1	1	1	1	1
	Total Managers Mean	3.369	3.452	4.04	2.177	3.023	2.738	3.152	2.945	2.385	3.196	1	1	1	1	1	1	1
	Frequencies																	
CEO	Score 1	4	8	3	24	9	19	11	13	28	6	45	38	51	12	49	53	57
	Score 2	8	8	3	16	6	6	10	10	10	5	0	0	0	0	0	0	0
	Score 3	10	11	6	11	13	13	9	11	9	9	0	0	0	0	0	0	0
	Score 4	17	15	8	10	12	7	7	13	10	7	0	0	0	0	0	0	0
	Score 5	12	19	10	2	13	15	15	10	6	4	0	0	0	0	0	0	0
	Score 6	14	7	2	3	12	3	8	7	3	1	0	0	0	0	0	0	0
	Score 7	4	0	3	2	1	3	5	2	1	1	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	Sample Size	*69*	*68*	*33*	*68*	*66*	*66*	*66*	*66*	*67*	*33*	*45*	*38*	*51*	*12*	*49*	*53*	*57*
Board Dir	Score 1	27	36	13	108	76	92	40	39	69	25	127	104	155	35	134	110	159
	Score 2	40	35	11	28	38	36	40	51	39	14	0	0	0	0	0	0	0
	Score 3	46	38	14	41	24	21	37	32	31	9	0	0	0	0	0	0	0
	Score 4	35	39	15	11	21	23	40	34	34	15	0	0	0	0	0	0	0
	Score 5	38	31	15	13	26	21	16	39	20	17	0	0	0	0	0	0	0
	Score 6	17	21	6	6	17	11	24	8	9	4	0	0	0	0	0	0	0
	Score 7	2	2	17	3	4	0	7	2	0	5	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*205*	*202*	*91*	*210*	*206*	*204*	*204*	*205*	*202*	*89*	*127*	*104*	*155*	*35*	*134*	*110*	*159*
Corporate	Score 1	22	21	8	72	35	40	34	33	46	20	70	46	88	25	63	52	96
	Score 2	28	31	9	16	20	22	27	39	36	10	0	0	0	0	0	0	0
	Score 3	28	18	12	14	11	10	20	13	17	6	0	0	0	0	0	0	0
	Score 4	22	18	7	10	18	13	17	20	15	3	0	0	0	0	0	0	0
	Score 5	17	21	4	8	23	24	9	9	8	8	0	0	0	0	0	0	0
	Score 6	8	16	5	1	14	13	13	6	1	6	0	0	0	0	0	0	0
	Score 7	2	2	9	3	2	1	5	4	0	3	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*127*	*127*	*54*	*124*	*123*	*123*	*125*	*124*	*123*	*56*	*70*	*46*	*88*	*25*	*63*	*52*	*96*
Clinical	Score 1	12	12	5	26	16	22	19	19	30	10	34	17	54	16	36	25	51
	Score 2	14	10	3	14	9	11	9	20	26	3	0	0	0	0	0	0	0
	Score 3	11	10	2	14	8	10	15	5	5	11	0	0	0	0	0	0	0
	Score 4	19	18	7	9	13	11	12	15	8	5	0	0	0	0	0	0	0
	Score 5	11	9	15	7	20	15	9	5	3	8	0	0	0	0	0	0	0
	Score 6	7	12	1	3	8	7	5	7	1	4	0	0	0	0	0	0	0
	Score 7	1	2	6	2	3	0	5	3	0	1	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*75*	*73*	*39*	*75*	*75*	*76*	*74*	*74*	*73*	*40*	*34*	*17*	*54*	*16*	*38*	*25*	*51*
Service	Score 1	50	45	11	165	101	115	88	95	135	23	138	96	190	62	165	123	214
	Score 2	57	48	20	53	60	51	59	55	50	27	0	0	0	0	0	0	0
	Score 3	63	66	23	36	28	36	40	49	46	28	0	0	0	0	0	0	0
	Score 4	59	55	13	22	35	34	51	34	28	15	0	0	0	0	0	0	0
	Score 5	50	41	24	21	49	41	30	37	31	20	0	0	0	0	0	0	0
	Score 6	23	40	16	7	22	20	22	21	8	8	0	0	0	0	0	0	0
	Score 7	2	6	16	1	6	3	11	9	0	9	0	0	0	0	0	0	0
	Score 8	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*304*	*301*	*127*	*306*	*301*	*300*	*301*	*300*	*298*	*130*	*138*	*96*	*190*	*62*	*165*	*123*	*214*
Other/Unidentified	Score 1	9	9	0	33	23	26	13	14	24	5	30	23	35	19	27	30	48
	Score 2	13	11	8	9	13	14	10	15	11	7	0	0	0	0	0	0	0
	Score 3	10	10	6	11	3	3	11	18	11	8	0	0	0	0	0	0	0
	Score 4	13	15	4	5	7	7	15	5	6	0	0	0	0	0	0	0	0
	Score 5	10	7	4	3	10	7	8	8	5	5	0	0	0	0	0	0	0
	Score 6	6	9	1	2	5	5	5	2	2	2	0	0	0	0	0	0	0
	Score 7	1	0	3	0	2	1	1	0	1	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*62*	*61*	*26*	*63*	*63*	*63*	*63*	*62*	*60*	*27*	*30*	*23*	*35*	*19*	*27*	*30*	*48*
	Chair Standard Deviation	1	1.826	1	2.51	1.517	2.49	1.924	1.626	2.449	2.082	0	0	0		0	0	0
	CEO S.D.	1.623	1.532	1.876	1.607	1.691	1.844	1.976	1.753	1.673	1.544	0	0	0	0	0	0	0
	Board Director S.D.	1.553	1.642	2.019	1.509	1.61	1.627	1.746	1.565	1.548	1.676	0	0	0	0	0	0	0
	Corporate S.D.	1.563	1.733	2.046	1.532	1.863	1.864	1.825	1.653	1.294	2.031	0	0	0	0	0	0	0
	Clinical S.D.	1.617	1.76	1.838	1.664	1.618	1.76	1.864	1.821	1.235	1.765	0	0	0	0	0	0	0
	Service S.D.	1.557	1.668	1.905	1.46	1.811	1.743	1.785	1.778	1.504	1.797	0	0	0	0	0	0	0
	Other/Unknown S.D.	1.533	1.628	1.687	1.406	1.916	1.811	1.641	1.413	1.588	1.581	0	0	0	0	0	0	0
	Total Managers S.D.	1.59	1.667	1.904	1.526	1.84	1.767	1.805	1.69	1.495	1.807	0	0	0	0	0	0	0

National Survey: Summary of Responses Showing Separate Categories of Managers

		3bN	3cM	3cC	3cT	3cN	4a	4b	4c	4d	4e	4f	4g	4h	4j	4k	4m	4n
	Chair Mean	1	1	1	1		2.2	2.8	2	2.8	2.8		2.6	2.6	2	3	2.8	
	CEO Mean	1	1	1	1	1	2.451	2.471	2.38	2.775	2.789	3	2.514	2.535	2.38	2.789	2.833	3
	Board Director Mean	1	1	1	1	1	2.529	2.543	2.445	2.676	2.743	2.828	2.671	2.611	2.531	2.698	2.859	2.767
	Corporate Mean	1	1	1	1	1	2.632	2.52	2.496	2.629	2.718	2.857	2.778	2.659	2.606	2.63	2.835	3
	Clinical Mean	1	1	1	1	1	2.577	2.603	2.59	2.513	2.662	2.571	2.792	2.558	2.5	2.623	2.907	2.5
	Service Mean	1	1	1	1	1	2.632	2.637	2.543	2.689	2.742	2.622	2.857	2.583	2.555	2.69	2.848	2.405
	Other/Unknown Mean	1	1	1	1	1	2.667	2.667	2.597	2.714	2.887	2.833	2.815	2.615	2.703	2.815	2.954	2.5
	Total Managers Mean	1	1	1	1	1	2.586	2.583	2.503	2.671	2.746	2.742	2.76	2.598	2.545	2.697	2.861	2.616
	Frequencies																	
CEO	Score 1	3	42	55	49	2	3	8	12	0	1	0	1	7	12	0	2	0
	Score 2	0	0	0	0	0	33	21	20	16	13	0	33	19	20	15	8	0
	Score 3	0	0	0	0	0	35	41	39	55	57	7	38	45	39	56	62	7
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*3*	*42*	*55*	*49*	*2*	*71*	*70*	*71*	*71*	*71*	*7*	*72*	*71*	*71*	*71*	*72*	*7*
Board Dir	Score 1	30	110	127	143	24	4	8	24	3	2	0	7	7	23	7	2	2
	Score 2	0	0	0	0	0	91	79	68	62	50	5	56	68	54	50	26	3
	Score 3	0	0	0	0	0	115	121	117	145	158	24	150	136	136	155	185	25
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*30*	*110*	*127*	*143*	*24*	*210*	*208*	*209*	*210*	*210*	*29*	*213*	*211*	*213*	*212*	*213*	*30*
Corporate	Score 1	22	60	72	91	11	2	2	7	1	4	0	2	7	11	7	5	0
	Score 2	0	0	0	0	0	42	56	49	44	27	1	24	29	28	33	11	0
	Score 3	0	0	0	0	0	81	87	89	79	93	6	100	90	88	87	111	7
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*22*	*60*	*72*	*91*	*11*	*125*	*125*	*125*	*124*	*124*	*7*	*125*	*126*	*127*	*127*	*127*	*7*
Clinical	Score 1	10	33	33	50	11	3	1	3	2	0	1	4	9	11	8	1	2
	Score 2	0	0	0	0	0	27	29	26	34	26	1	8	16	16	17	5	1
	Score 3	0	0	0	0	0	48	48	49	42	51	5	65	52	49	54	69	7
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*10*	*33*	*33*	*50*	*11*	*78*	*78*	*78*	*78*	*77*	*7*	*77*	*77*	*76*	*77*	*75*	*10*
Service	Score 1	43	149	157	211	37	10	7	26	3	3	4	8	25	36	14	5	7
	Score 2	0	0	0	0	0	89	92	82	85	89	6	27	73	61	64	35	6
	Score 3	0	0	0	0	0	197	193	185	205	219	27	266	197	202	219	257	22
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*43*	*149*	*157*	*211*	*37*	*296*	*292*	*293*	*293*	*291*	*37*	*301*	*295*	*299*	*297*	*297*	*37*
Other/Unidentified	Score 1	10	30	38	51	4	0	2	6	1	0	0	1	6	6	2	0	2
	Score 2	0	0	0	0	0	21	17	13	18	7	1	10	13	7	8	3	0
	Score 3	0	0	0	0	0	42	44	43	46	55	5	54	46	51	55	62	6
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*10*	*30*	*38*	*51*	*4*	*63*	*63*	*62*	*63*	*62*	*6*	*65*	*65*	*64*	*65*	*65*	*8*
	Chair Standard Deviation	0	0	0	0		0.447	0.447	0.707	0.447	0.447		0.548	0.894	0.707	0	0.447	
	CEO S.D.	0	0	0	0	0	0.58	0.696	0.763	0.421	0.445	0	0.531	0.873	0.763	0.411	0.444	0
	Board Director S.D.	0	0	0	0	0	0.537	0.572	0.592	0.499	0.459	0.384	0.536	0.553	0.684	0.527	0.375	0.568
	Corporate S.D.	0	0	0	0	0	0.516	0.533	0.604	0.502	0.519	0.378	0.454	0.582	0.844	0.588	0.467	0
	Clinical S.D.	0	0	0	0	0	0.57	0.518	0.568	0.552	0.476	0.787	0.522	0.698	0.739	0.629	0.336	0.85
	Service S.D.	0	0	0	0	0	0.549	0.529	0.654	0.485	0.461	0.681	0.42	0.643	0.7	0.556	0.403	0.798
	Other/Unknown S.D.	0	0	0	0	0	0.475	0.539	0.664	0.49	0.319	0.408	0.429	0.654	0.634	0.464	0.211	0.926
	Total Managers S.D.	0	0	0	0	0	0.543	0.557	0.662	0.495	0.462	0.55	0.486	0.622	0.695	0.544	0.394	0.71

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		5a	5b	6a	6b	Q7	a_Co	8a_Nu	a_Ma	a_ChE	8a_TB	8a_Pu	8a_Ot	b_Co	8b_Nu	b_Ma	b_ChE	8b_TB
	Chair Mean	4.2	28	4	51.2	1.4	1			1		1		1	1	1	1	
	CEO Mean	4.188	39.5	4	37.91	1.271	1	1	1	1	1	1		1	1	1	1	1
	Board Director Mean	3.939	41.59	3.896	33.67	1.305	1	1	1	1	1	1		1	1	1	1	1
	Corporate Mean	3.776	41.39	3.685	33.02	1.388	1	1	1	1	1	1		1	1	1	1	1
	Clinical Mean	3.312	40.85	3.392	32.38	1.776	1	1	1	1	1	1		1	1	1	1	1
	Service Mean	3.53	41.46	3.627	34.62	1.561	1	1	1	1	1	1	1	1	1	1	1	1
	Other/Unknown Mean	3.516	48.2	3.762	35.55	1.403	1	1	1	1	1	1		1	1	1	1	1
	Total Managers Mean	3.705	41.65	3.722	34.41	1.454	1	1	1	1	1	1	1	1	1	1	1	1
	Frequencies																	
CEO	Score 1	0	0	0	0	57	32	3	12	6	6	26	3	15	6	40	5	4
	Score 2	2	0	3	0	7	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	4	0	2	0	6	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	42	0	55	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	21	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*69*	*0*	*68*	*0*	*70*	*32*	*3*	*12*	*6*	*6*	*26*	*3*	*15*	*6*	*40*	*5*	*4*
Board Dir	Score 1	3	0	0	0	185	69	7	25	35	23	84	9	37	13	96	21	33
	Score 2	8	0	13	0	33	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	36	0	25	0	16	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	118	0	145	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	48	0	29	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*213*	*0*	*212*	*0*	*214*	*69*	*7*	*25*	*35*	*23*	*84*	*9*	*37*	*13*	*96*	*21*	*33*
Corporate	Score 1	1	0	2	0	86	39	7	21	19	11	49	4	17	7	57	14	16
	Score 2	14	0	16	0	29	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	19	0	13	0	9	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	69	0	81	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	22	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*125*	*0*	*124*	*0*	*124*	*39*	*7*	*21*	*19*	*11*	*49*	*4*	*17*	*7*	*57*	*14*	*16*
Clinical	Score 1	1	0	4	0	40	20	4	15	10	7	37	3	12	5	35	5	12
	Score 2	23	0	14	0	13	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	11	0	14	0	23	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	35	0	41	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	7	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*77*	*0*	*79*	*0*	*76*	*20*	*4*	*15*	*10*	*7*	*37*	*3*	*12*	*5*	*35*	*5*	*12*
Service	Score 1	9	0	3	1	187	84	12	53	24	37	148	10	52	15	117	27	53
	Score 2	46	0	37	0	63	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	53	1	48	0	52	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	161	0	197	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	31	0	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*300*	*1*	*303*	*1*	*303*	*84*	*12*	*53*	*24*	*37*	*148*	*10*	*52*	*15*	*117*	*27*	*53*
Other/Unidentified	Score 1	0	0	0	0	45	18	2	13	8	6	27	0	14	2	30	6	8
	Score 2	11	0	4	0	9	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	13	0	10	0	8	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	33	0	46	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	5	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*62*	*0*	*63*	*0*	*62*	*18*	*2*	*13*	*8*	*6*	*27*	*0*	*14*	*2*	*30*	*6*	*8*
	Chair Standard Deviation	0.447	10.95	0	9.96	0.548	0			0					0	0		
	CEO S.D.	0.67	22.97	0.573	20.32	0.812	0	0	0	0	0	0		0	0	0	0	0
	Board Director S.D.	0.819	23.66	0.701	19.31	0.601	0	0	0	0	0	0		0	0	0	0	0
	Corporate S.D.	0.897	21.85	0.678	17.64	0.625	0	0	0	0	0	0		0	0	0	0	0
	Clinical S.D.	1.042	21.36	1.031	19.1	0.888	0	0	0	0	0	0		0	0	0	0	0
	Service S.D.	0.972	20.15	0.811	19.02	0.782	0	0	0	0	0	0		0	0	0	0	0
	Other/Unknown S.D.	0.882	24.88	0.64	19.21	0.712	0	0	0	0	0	0		0	0	0	0	0
	Total Managers S.D.	0.932	21.99	0.604	19.02	0.723	0	0	0	0	0	0		0	0	0	0	0

National Survey: Summary of Responses Showing Separate Categories of Managers

		8b_Pu	8b_Ot	c_Co	8c_Nu	c_Ma	c_ChE	8c_TB	8c_Pu	8c_Ot	d_Co	8d_Nu	d_Ma	d_ChE	8d_TB	8d_Pu	8d_Ot	e_Co
	Chair Mean			1	1	1	1	1	1		1	1	1	1	1	1		1
	CEO Mean	1		1		1	1	1	1		1	1	1	1	1	1		1
	Board Director Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		1
	Corporate Mean	1		1		1	1	1	1			1	1	1	1	1		1
	Clinical Mean	1		1		1	1	1	1		1	1	1	1	1	1		1
	Service Mean	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Other/Unknown Mean	1		1		1	1	1	1	1		1	1	1	1	1		1
	Total Managers Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Frequencies																	
CEO	Score 1	3	4	23	0	15	14	9	12	6	1	18	37	5	10	7	5	63
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*3*	*4*	*23*	*0*	*15*	*14*	*9*	*12*	*6*	*1*	*18*	*37*	*5*	*10*	*7*	*5*	*63*
Board Dir	Score 1	36	10	88	1	26	46	36	29	16	5	60	113	22	28	20	9	193
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*36*	*10*	*88*	*1*	*26*	*46*	*36*	*29*	*16*	*5*	*60*	*113*	*22*	*28*	*20*	*9*	*193*
Corporate	Score 1	23	2	64	0	8	18	20	18	10	0	29	65	5	18	15	6	110
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*23*	*2*	*64*	*0*	*8*	*18*	*20*	*18*	*10*	*0*	*29*	*65*	*5*	*18*	*15*	*6*	*110*
Clinical	Score 1	17	1	30	0	10	14	21	9	3	2	16	49	6	11	6	2	56
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*17*	*1*	*30*	*0*	*10*	*14*	*21*	*9*	*3*	*2*	*16*	*49*	*6*	*11*	*6*	*2*	*56*
Service	Score 1	62	6	133	2	44	43	59	49	19	3	61	166	19	57	43	8	243
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*62*	*6*	*133*	*2*	*44*	*43*	*59*	*49*	*19*	*3*	*61*	*166*	*19*	*57*	*43*	*8*	*243*
Other/Unidentified	Score 1	10	0	31	0	11	7	10	8	5	0	17	34	2	14	6	3	52
	Score 2	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*10*	*0*	*31*	*0*	*11*	*7*	*10*	*8*	*5*	*0*	*17*	*34*	*2*	*14*	*6*	*3*	*52*
	Chair Standard Deviation						0	0	0			0	0	0	0			0
	CEO S.D.	0		0		0	0	0	0			0	0	0	0	0		0
	Board Director S.D.	0	0	0		0	0	0	0	0	0	0	0	0	0	0		0
	Corporate S.D.	0		0		0	0	0	0			0	0	0	0	0		0
	Clinical S.D.	0		0		0	0	0	0		0	0	0	0	0	0		0
	Service S.D.	0		0	0	0	0	0	0	0	0	0	0	0	0	0		0
	Other/Unknown S.D.	0		0		0	0	0	0			0	0	0	0	0		0
	Total Managers S.D.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0

National Survey: Summary of Responses Showing Separate Categories of Managers

		8e_Nu	e_Ma	e_ChE	8e_TB	8e_Pu	8e_Ot	8f_Co	8f_Nur	8f_Ma	f_ChE	8f_TB	8f_Pur	8f_Oth	Q9	10a	10b	10c
	Chair Mean			1			1	1		1	1		1		2	1.8	50	
	CEO Mean	1	1			1	1	1	1	1			1		2.153	1.792	12.5	46.67
	Board Director Mean	1	1	1	1	1		1	1	1	1	1	1		2.206	1.863	37.71	42.73
	Corporate Mean	1	1	1		1		1	1	1			1		2.145	1.923	36.52	28.89
	Clinical Mean	1	1			1		1	1	1	1		1	1	2.025	1.75	52.73	38.33
	Service Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	2.003	1.788	34.52	46.82
	Other/Unknown Mean	1	1		1	1		1		1			1		2.044	1.791	36	13.33
	Total Managers Mean	1	1	1	1	1	1	1	1	1	1	1	1	1	2.091	1.824	37.01	40.53
	Frequencies																	
CEO	Score 1	3	4	0	0	2	4	70	1	2	0	0	2	1	9	26	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	43	38	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	20	5	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*3*	*4*	*0*	*0*	*2*	*4*	*70*	*1*	*2*	*0*	*0*	*2*	*1*	*72*	*72*	*0*	*0*
Board Dir	Score 1	11	14	2	2	11	7	208	14	2	3	3	15	6	17	76	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	139	108	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	62	24	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*11*	*14*	*2*	*2*	*11*	*7*	*208*	*14*	*2*	*3*	*3*	*15*	*6*	*218*	*219*	*0*	*0*
Corporate	Score 1	3	11	2	0	9	1	114	9	3	0	0	8	5	8	40	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	96	68	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	27	15	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*3*	*11*	*2*	*0*	*9*	*1*	*114*	*9*	*3*	*0*	*0*	*8*	*5*	*131*	*130*	*0*	*0*
Clinical	Score 1	4	12	0	0	7	1	63	6	2	1	0	11	7	10	36	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	59	29	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	12	14	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*4*	*12*	*0*	*0*	*7*	*1*	*63*	*6*	*2*	*1*	*0*	*11*	*7*	*81*	*80*	*0*	*0*
Service	Score 1	13	44	5	6	25	7	274	16	15	3	6	27	5	48	126	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	215	138	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	49	34	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*13*	*44*	*5*	*6*	*25*	*7*	*274*	*16*	*15*	*3*	*6*	*27*	*5*	*312*	*311*	*0*	*0*
Other/Unidentified	Score 1	2	8	0	1	3	1	63	0	2	0	0	6	0	9	23	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	47	37	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	12	5	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Sample Size	*2*	*8*	*0*	*1*	*3*	*1*	*63*	*0*	*2*	*0*	*0*	*6*	*0*	*68*	*67*	*0*	*0*
	Chair Standard Deviation							0							0.707	0.837	56.57	
	CEO S.D.	0	0			0		0		0			0		0.62	0.749	5	34.45
	Board Director S.D.	0	0	0	0	0		0	0	0	0	0	0		0.567	0.801	36.39	38.49
	Corporate S.D.	0	0	0		0		0	0	0			0		0.498	0.822	36.38	29.77
	Clinical S.D.	0	0			0		0	0	0			0		0.524	0.788	41.01	37.1
	Service S.D.	0	0	0	0	0		0	0	0	0	0	0		0.558	0.799	35.97	39.69
	Other/Unknown S.D.	0	0			0		0		0			0		0.556	0.706	35.02	5.774
	Total Managers S.D.	0	0	0	0	0	0	0	0	0	0	0	0	0	0.56	0.791	36.06	35.98

Stage 1 of the Questionnaire Survey: Summary of Responses to Question 2 from Site A

		2a	2b	2c	2d	2e	2f	2g	2h	2j	2k	2m	2n	2p	2q	2r	2s	2t	2u
Doctors	Score 1	1	3	5	1	3	3	0	5	0	2	3	3	3	0	0	2	4	1
	Score 2	1	2	2	1	1	2	1	1	2	2	1	0	0	0	0	2	2	1
	Score 3	1	3	2	1	0	2	0	0	3	3	1	1	1	0	3	1	1	1
	Score 4	3	1	0	1	1	2	2	1	2	0	1	0	1	0	3	3	1	1
	Score 5	2	0	0	1	1	0	1	0	0	0	0	2	1	0	0	0	0	2
	Score 6	1	0	0	2	2	0	0	0	0	0	1	1	1	1	1	0	0	2
	Score 7	0	0	0	2	1	0	1	0	0	0	0	0	0	2	1	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Managers	Score 1	7	4	6	2	2	2	1	5	3	2	0	0	2	0	0	5	7	0
	Score 2	3	4	2	3	1	1	1	3	6	6	4	2	3	0	0	0	1	1
	Score 3	2	2	3	2	4	5	0	2	2	3	2	4	1	2	3	4	1	0
	Score 4	0	1	1	5	2	2	0	0	2	0	4	5	2	0	3	1	2	2
	Score 5	0	1	1	1	2	2	2	0	0	2	2	1	3	2	1	2	0	6
	Score 6	1	1	0	0	2	1	0	3	0	0	1	1	2	0	5	1	2	2
	Score 7	0	0	0	0	0	0	2	0	0	0	0	0	0	1	1	0	0	2
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Score 1	8	7	11	3	5	5	1	10	3	4	3	3	5	0	0	7	11	1
	Score 2	4	6	4	4	2	3	2	4	8	8	5	2	3	0	0	2	3	2
	Score 3	3	5	5	3	4	7	0	2	5	6	3	5	2	2	6	5	2	1
	Score 4	3	2	1	6	3	4	2	1	4	0	5	5	3	0	6	4	3	3
	Score 5	2	1	1	2	3	2	3	0	0	2	2	3	4	2	1	2	0	8
	Score 6	2	1	0	2	4	1	0	3	0	0	2	2	3	1	6	1	2	4
	Score 7	0	0	0	2	1	0	3	0	0	0	0	0	0	3	2	0	0	2
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Doctor Mean		3.78	2.22	1.67	4.56	3.67	2.33	4.40	1.57	3.00	2.14	2.57	3.14	3.00	6.67	4.25	2.63	1.88	4.00
ical Directorate Mean		3.25	2.00	2.00	5.00	4.75	3.25	3.67	1.25	3.00	2.50	3.00	3.75	3.25	6.67	4.50	2.25	2.25	4.50
Board Director Mean		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
onsultant Only Mean		4.20	2.40	1.40	4.20	2.80	1.80	5.50	2.00	3.00	1.67	2.00	2.33	2.67	#DIV/0!	4.00	3.00	1.50	3.50
Chair	Score 1	1	1	1	0	0	0	0	3	0	0	1	1	1	0	0	1	1	0
	Score 2	0	2	2	0	1	1	1	1	1	2	1	0	0	0	0	2	2	0
	Score 3	1	1	1	1	0	1	0	0	2	2	1	1	1	0	1	0	0	1
	Score 4	1	0	0	1	1	2	1	0	1	0	0	0	1	0	2	1	1	1
	Score 5	1	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	0	1
	Score 6	0	0	0	1	1	0	0	0	0	0	1	1	0	1	0	0	0	1
	Score 7	0	0	0	1	1	0	0	0	0	0	0	0	0	2	1	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Board	Score 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Stage 1 of the Questionnaire Survey: Summary of Responses to Question 2 from Site A

		2a	2b	2c	2d	2e	2f	2g	2h	2j	2k	2m	2n	2p	2q	2r	2s	2t	2u
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultant	Score 1	0	2	4	1	3	3	0	2	0	2	2	2	2	0	0	1	3	1
	Score 2	1	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	1
	Score 3	0	2	1	0	0	1	0	0	1	1	0	0	0	0	2	1	1	0
	Score 4	2	1	0	0	0	0	1	1	1	0	1	0	0	0	1	2	0	0
	Score 5	1	0	0	1	1	0	0	0	0	0	0	1	0	0	0	0	0	1
	Score 6	1	0	0	1	1	0	0	0	0	0	0	0	1	0	1	0	0	1
	Score 7	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Standard Deviation		1.563	1.093	0.866	2.186	2.449	1.225	1.817	1.134	0.818	0.900	1.902	2.193	2.082	0.577	1.488	1.302	1.126	1.852
of Clinical Directorate S.D.		1.708	0.818	0.816	1.826	2.217	0.957	1.528	0.500	0.816	0.577	2.160	2.217	1.708	0.577	1.732	1.258	1.258	1.291
Board Director S.D.		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Consultant Only S.D.		1.483	1.342	0.894	2.588	2.490	0.894	2.121	1.732	1.000	1.155	1.732	2.309	2.887	#DIV/0!	1.414	1.414	1.000	2.380
Chair Mean																			
CEO Mean		1	6	5	4	2	3	#DIV/0!	6	1	2	3	4	5	#DIV/0!	6	3	4	5
Board Director Mean		3.000	1.000	1.000	1.000	1.000	1.000	#DIV/0!	3.000	1.000	5.000	2.000	2.000	4.000	#DIV/0!	6.000	1.000	6.000	2.000
Corporate Mean		2.000	2.800	2.400	2.400	3.600	3.200	4.000	3.400	3.000	2.400	4.000	4.200	2.800	5.000	5.800	4.400	2.600	5.800
Clinical Mean		2.000	2.000	2.000	3.000	3.000	3.000	2.000	2.000	2.000	2.000	2.000	2.000	2.000	3.000	3.000	3.000	3.000	4.000
Service Mean		2.000	2.000	1.250	3.750	4.250	3.500	5.667	1.500	2.000	2.250	3.750	3.250	3.750	5.000	4.000	1.750	1.000	5.000
ther/Unknown Mean		1.000	2.000	3.000	4.000	5.000	6.000	#DIV/0!	1.000	2.000	3.000	4.000	5.000	6.000	#DIV/0!	3.000	1.000	2.000	6.000
otal Managers Mean		1.923	2.538	2.154	3.000	3.538	3.308	4.500	2.692	2.231	2.538	3.538	3.615	3.538	4.600	4.846	2.846	2.462	5.077
CEO	Score 1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	Score 2	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	0	0
	Score 4	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	1	0
	Score 5	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
	Score 6	0	1	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Board Dir	Score 1	0	1	1	1	1	1	0	0	1	0	0	0	0	0	0	1	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1
	Score 3	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporate	Score 1	4	2	2	1	1	1	1	2	0	0	0	0	2	0	0	0	3	0
	Score 2	0	0	0	3	0	0	0	0	2	3	2	0	1	0	0	0	0	0

Stage 1 of the Questionnaire Survey: Summary of Responses to Question 2 from Site A

		2a	2b	2c	2d	2e	2f	2g	2h	2j	2k	2m	2n	2p	2q	2r	2s	2t	2u
	Score 3	0	1	2	0	2	2	0	1	1	2	0	1	0	1	0	2	0	0
	Score 4	0	1	1	0	0	1	0	0	2	0	0	3	0	0	1	0	1	0
	Score 5	0	1	0	1	1	1	0	0	0	0	2	0	2	0	0	2	0	3
	Score 6	1	0	0	0	1	0	0	2	0	0	1	1	0	0	3	1	1	0
	Score 7	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	0	0	2
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical	Score 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 2	1	1	1	0	0	0	1	1	1	1	1	1	1	0	0	0	0	0
	Score 3	0	0	0	1	1	1	0	0	0	0	0	0	0	1	1	1	1	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Service	Score 1	1	1	3	0	0	0	0	2	1	2	0	0	0	0	0	3	4	0
	Score 2	2	2	1	0	0	1	0	2	2	1	0	0	1	0	0	0	0	0
	Score 3	1	1	0	1	1	1	0	0	1	0	1	3	1	0	1	0	0	0
	Score 4	0	0	0	3	2	1	0	0	0	0	3	1	1	0	2	1	0	1
	Score 5	0	0	0	0	0	1	2	0	0	1	0	0	0	2	1	0	0	2
	Score 6	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	1
	Score 7	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
r/Unidentified	Score 1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0
	Score 2	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
	Score 3	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0
	Score 4	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Score 5	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0
	Score 6	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Stage 1 of the Questionnaire Survey: Summary of Responses to Question 2 from Site A

		2v	2w	2x	2y	2z	2aa	2ab	2ac	2ad	2ae	2af	2ag	2ah	2aj	2ak	2am	2an
Doctors	Score 1	2	3	0	4	0	2	2	2	2	0	2	2	4	3	2	4	1
	Score 2	1	2	1	3	2	3	3	3	3	0	3	1	1	2	3	2	0
	Score 3	1	0	1	0	2	1	0	1	1	0	0	2	0	1	2	2	0
	Score 4	1	2	0	1	2	1	2	0	0	0	2	0	0	0	0	0	2
	Score 5	2	1	0	0	1	1	0	0	2	0	0	1	2	1	0	0	0
	Score 6	1	0	0	0	1	0	1	2	0	1	0	2	1	0	1	0	0
	Score 7	0	0	1	0	0	0	0	0	0	2	1	0	0	1	0	0	1
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Managers	Score 1	2	1	0	9	1	2	2	1	0	0	8	4	5	4	2	3	1
	Score 2	2	8	1	1	6	5	4	3	3	0	0	4	3	5	3	5	1
	Score 3	3	3	2	2	3	2	3	2	3	1	3	1	3	1	2	0	0
	Score 4	4	0	1	0	1	1	4	4	2	0	1	2	0	1	2	3	1
	Score 5	0	1	1	0	1	2	0	3	1	4	0	1	2	1	3	1	1
	Score 6	1	2	0	1	1	1	0	0	3	0	1	1	0	1	1	1	0
	Score 7	1	0	2	0	0	0	0	0	1	1	0	0	0	0	0	0	2
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Score 1	4	4	0	13	1	4	4	3	2	0	10	6	9	7	4	7	2
	Score 2	3	8	2	4	8	8	7	6	6	0	3	5	4	7	6	7	1
	Score 3	4	3	3	2	5	3	3	3	4	1	3	3	3	2	4	2	0
	Score 4	5	2	1	1	3	2	6	4	2	0	3	2	0	1	2	3	3
	Score 5	2	2	1	0	2	3	0	3	3	4	0	2	4	2	3	1	1
	Score 6	2	2	0	1	2	1	1	2	3	1	1	3	1	1	2	1	0
	Score 7	1	0	3	0	0	0	0	0	1	3	1	0	0	1	0	0	3
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Doctor Mean		3.38	2.50	4.00	1.75	3.63	2.50	2.75	2.88	2.63	6.67	2.88	3.38	2.75	2.75	2.50	1.75	4.00
ical Directorate Mean		4.25	3.75	4.00	1.50	3.25	2.75	2.75	3.00	3.00	6.67	3.00	3.00	2.25	4.00	3.50	2.00	3.00
Board Director Mean		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
onsultant Only Mean		2.50	1.25	#DIV/0!	2.00	4.00	2.25	2.75	2.75	2.25	#DIV/0!	2.75	3.75	3.25	1.50	1.50	1.50	7.00
Chair	Score 1	0	0	0	2	0	0	1	0	0	0	1	1	2	0	0	1	1
	Score 2	1	1	1	2	2	2	2	3	2	0	2	1	1	2	1	2	0
	Score 3	0	0	1	0	0	1	0	0	1	0	0	1	0	0	2	1	0
	Score 4	1	2	0	0	1	1	0	0	0	0	0	0	0	0	0	0	2
	Score 5	1	1	0	0	1	0	0	0	1	0	0	0	1	1	0	0	0
	Score 6	1	0	0	0	0	0	1	1	0	1	0	1	0	0	1	0	0
	Score 7	0	0	1	0	0	0	0	0	0	2	1	0	0	1	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Board	Score 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Stage 1 of the Questionnaire Survey: Summary of Responses to Question 2 from Site A

		2v	2w	2x	2y	2z	2aa	2ab	2ac	2ad	2ae	2af	2ag	2ah	2aj	2ak	2am	2an
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultant	Score 1	2	3	0	2	0	2	1	2	2	0	1	1	2	3	2	3	0
	Score 2	0	1	0	1	0	1	1	0	1	0	1	0	0	0	2	0	0
	Score 3	1	0	0	0	2	0	0	1	0	0	0	1	0	1	0	1	0
	Score 4	0	0	0	1	1	0	2	0	0	0	2	0	0	0	0	0	0
	Score 5	1	0	0	0	0	1	0	0	1	0	0	1	1	0	0	0	0
	Score 6	0	0	0	0	1	0	0	1	0	0	0	1	1	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Standard Deviation		1.923	1.604	2.646	1.035	1.406	1.414	1.753	2.031	1.598	0.577	2.031	2.066	2.188	2.188	1.604	0.886	2.449
of Clinical Directorate S.D.		1.708	1.258	2.646	0.577	1.500	0.957	2.217	2.000	1.414	0.577	2.708	2.160	1.893	2.449	1.732	0.816	1.732
Board Director S.D.		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Consultant Only S.D.		1.915	0.500	#DIV/0!	1.414	1.414	1.893	1.500	2.363	1.893	#DIV/0!	1.500	2.217	2.630	1.000	0.577	1.000	#DIV/0!
Chair Mean																		
CEO Mean		1	2	#DIV/0!	1	6	5	4	2	3	#DIV/0!	4	6	5	1	3	2	#DIV/0!
Board Director Mean		2.000	6.000	#DIV/0!	1.000	3.000	3.000	2.000	3.000	3.000	#DIV/0!	1.000	2.000	2.000	1.000	1.000	1.000	#DIV/0!
Corporate Mean		4.400	3.000	4.000	2.800	2.600	2.400	2.600	3.400	4.600	6.000	2.400	2.800	2.600	1.600	3.800	3.200	4.000
Clinical Mean		3.000	3.000	3.000	1.000	2.000	2.000	1.000	2.000	2.000	3.000	1.000	2.000	2.000	2.000	2.000	2.000	2.000
Service Mean		3.000	2.000	5.333	1.250	2.500	3.250	2.500	3.750	4.000	5.000	2.000	2.000	1.250	4.000	3.250	2.250	5.333
ther/Unknown Mean		4.000	5.000	#DIV/0!	1.000	2.000	3.000	4.000	5.000	6.000	#DIV/0!	1.000	2.000	3.000	4.000	5.000	6.000	#DIV/0!
otal Managers Mean		3.385	3.000	4.429	1.769	2.846	2.923	2.692	3.385	4.077	5.000	2.077	2.615	2.308	2.462	3.308	2.769	4.333
CEO	Score 1	1	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
	Score 2	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
	Score 3	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0
	Score 4	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0
	Score 5	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0
	Score 6	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Board Dir	Score 1	0	0	0	1	0	0	0	0	0	0	1	0	0	1	1	1	0
	Score 2	1	0	0	0	0	0	1	0	0	0	0	1	1	0	0	0	0
	Score 3	0	0	0	0	1	1	0	1	1	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporate	Score 1	1	0	0	2	1	1	1	1	0	0	3	2	2	2	1	1	1
	Score 2	0	3	1	0	1	3	1	1	1	0	0	0	0	3	0	1	0

Stage 1 of the Questionnaire Survey: Summary of Responses to Question 2 from Site A

		2v	2w	2x	2y	2z	2aa	2ab	2ac	2ad	2ae	2af	2ag	2ah	2aj	2ak	2am	2an
	Score 3	0	1	1	2	2	0	1	0	0	0	1	1	2	0	1	0	0
	Score 4	2	0	0	0	0	0	2	1	1	0	0	1	0	0	1	2	0
	Score 5	0	0	0	0	1	1	0	2	1	1	0	1	1	0	1	1	0
	Score 6	1	1	0	1	0	0	0	0	2	0	1	0	0	0	1	0	0
	Score 7	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical	Score 1	0	0	0	1	0	0	1	0	0	0	1	0	0	0	0	0	0
	Score 2	0	0	0	0	1	1	0	1	1	0	0	1	1	1	1	1	1
	Score 3	1	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Service	Score 1	0	1	0	3	0	1	0	0	0	0	2	2	3	0	0	1	0
	Score 2	1	2	0	1	3	1	2	0	1	0	0	1	1	1	2	2	0
	Score 3	2	1	0	0	0	0	2	1	1	0	2	0	0	1	0	0	0
	Score 4	1	0	1	0	1	1	0	3	1	0	0	1	0	0	1	1	1
	Score 5	0	0	1	0	0	0	0	0	0	3	0	0	0	1	1	0	1
	Score 6	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0
	Score 7	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
n\Unidentified	Score 1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0
	Score 2	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0
	Score 3	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0
	Score 4	1	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0
	Score 5	0	1	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0
	Score 6	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Stage 3 of Questionnaire Survey: Summary of Responses from Hospitals A and B

		q2a	q2b	q2c	q2d	q2e	q2f	q2g	q2h	q2i	q2k	q2m	q2n	q2p	q2q	q2r	q2s	q2t	q2u	q2v	q2w	q2x	q2y	q2z	q2aa	q2ab	q2ac
Sample Mean		2.90	2.33	1.90	3.51	3.44	2.90	4.71	1.90	2.63	3.20	2.62	3.00	3.56	5.77	4.35	2.45	2.18	3.87	3.13	2.87	4.43	1.53	2.96	3.05	2.31	2.97
Sample Standard Deviation		1.83	1.48	1.28	1.72	1.73	1.86	1.93	1.48	1.20	1.42	1.41	1.43	1.89	1.48	1.78	1.50	1.52	1.77	1.61	1.51	1.78	1.09	1.39	1.50	1.24	1.53
Hospital B Mean		3.15	2.25	1.85	3.37	3.26	2.89	5.17	1.50	3.15	4.00	2.00	2.53	3.79	6.40	4.05	2.11	2.11	3.17	2.83	2.50	4.25	1.26	2.79	3.37	1.83	2.72
Hospital B Standard Deviation		1.98	1.59	1.42	1.61	1.45	1.81	1.60	0.95	1.31	1.21	0.88	1.17	1.93	0.89	2.09	1.37	1.37	1.85	1.36	1.42	0.96	0.73	1.36	1.46	0.92	1.45
Hospital A Mean		2.68	2.41	1.95	3.64	3.59	2.91	4.45	2.30	2.50	2.40	3.20	3.45	3.35	5.38	4.62	2.76	2.24	4.67	3.38	2.81	4.30	1.78	3.14	2.76	2.71	3.19
Hospital A Standard Deviation		1.73	1.40	1.17	1.64	1.97	1.44	2.11	1.81	1.00	1.14	1.58	1.54	1.87	1.69	1.43	1.58	1.67	1.59	1.77	1.60	2.06	1.30	1.42	1.51	1.35	1.60
Hospital B	Score 1	5	5	12	2	4	6	8	15	3	0	5	5	3	0	4	9	9	3	5	5	0	16	4	3	7	5
	Score 2	3	6	5	4	2	4	0	1	3	3	11	3	2	0	1	4	4	4	2	6	0	2	4	2	9	3
	Score 3	5	3	0	6	1	3	1	3	5	4	1	6	5	0	2	3	3	4	3	2	0	0	6	5	0	5
	Score 4	2	1	0	4	9	2	1	1	6	4	2	2	2	0	4	1	1	3	7	4	2	1	2	3	2	2
	Score 5	2	1	3	2	3	0	2	0	3	8	0	1	0	1	0	2	2	3	1	0	1	0	3	6	0	3
	Score 6	4	0	0	1	0	4	0	0	8	1	0	0	7	1	7	0	0	0	0	1	1	0	0	0	0	0
	Score 7	0	1	0	1	0	0	2	0	0	0	0	0	0	3	1	0	0	1	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A	Score 1	8	7	11	3	5	5	1	10	3	4	3	3	5	0	0	7	11	1	4	4	0	13	1	4	4	3
	Score 2	4	6	4	4	2	3	2	4	5	5	5	2	3	0	0	2	3	5	3	6	2	4	8	8	7	6
	Score 3	3	5	5	3	4	7	6	2	5	5	3	5	2	2	6	5	2	1	4	3	3	2	5	3	3	3
	Score 4	3	2	1	6	3	4	2	1	4	0	5	5	3	0	6	4	3	3	5	2	1	1	3	2	6	4
	Score 5	2	1	1	2	3	2	3	0	0	3	2	3	4	2	1	2	0	6	2	2	1	0	2	3	0	3
	Score 6	2	1	0	2	4	1	6	3	0	0	2	2	3	1	6	1	2	4	2	2	0	1	2	1	1	2
	Score 7	0	0	0	2	1	0	3	0	0	0	0	6	0	3	2	0	0	2	1	0	3	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0
Total	Score 1	14	15	23	5	9	11	1	25	6	4	8	8	5	0	4	18	20	4	9	9	0	29	5	7	11	6
	Score 2	7	12	8	8	4	7	2	5	11	11	16	5	5	0	1	8	7	8	5	14	2	8	12	10	16	9
	Score 3	6	8	5	8	5	10	1	5	10	10	4	13	7	2	8	8	5	5	7	5	3	2	11	6	3	6
	Score 4	5	3	1	10	12	6	3	2	10	4	7	7	5	0	10	5	4	6	12	8	3	2	5	5	6	6
	Score 5	4	2	4	4	6	2	5	0	3	10	2	4	4	3	1	4	2	11	3	2	2	0	5	9	0	6
	Score 6	6	1	0	3	4	5	0	3	0	1	2	2	10	2	13	1	2	4	2	3	1	1	2	1	1	2
	Score 7	0	1	6	3	1	0	5	0	0	0	0	0	0	6	3	0	0	3	1	0	3	0	0	0	6	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
tal Hospital B Doctor Mean		3.79	2.50	1.71	3.43	3.28	2.67	5.17	1.38	3.50	4.43	1.78	2.50	3.88	6.40	4.15	2.00	2.00	3.23	3.31	2.69	4.75	1.38	3.23	4.00	1.62	2.38
tal Hospital A Doctor Mean		3.78	2.22	1.67	4.56	3.67	2.33	4.40	1.57	3.00	2.14	2.57	3.14	3.00	6.67	4.25	2.63	1.88	4.00	3.38	2.50	4.00	1.75	3.63	2.50	2.75	2.88
l Hospital B Manager Mean		1.87	1.67	2.17	3.20	3.20	3.00	#DIV/0!	1.83	2.33	3.00	2.60	2.60	3.60	#DIV/0!	3.83	2.33	2.33	3.00	1.60	2.00	#DIV/0!	1.00	1.83	2.00	2.40	3.60
l Hospital A Manager Mean		1.82	2.54	2.15	3.00	3.54	3.31	4.50	2.89	2.23	2.54	3.54	3.62	3.54	4.60	4.85	2.85	2.46	5.06	3.38	3.00	4.43	1.77	2.85	2.92	2.69	3.38
Hospital B Doctor	Score 1	3	6	10	2	3	5	0	11	1	0	5	4	2	8	3	7	8	2	2	3	0	10	2	1	5	5
	Score 2	1	2	2	3	1	3	0	1	1	0	6	1	1	0	1	2	1	3	1	4	0	2	1	0	6	1
	Score 3	2	3	0	3	1	3	1	2	5	4	6	7	4	0	0	2	2	3	2	2	0	0	5	3	0	5
	Score 4	2	1	0	2	7	1	1	0	4	1	1	2	2	0	3	1	0	2	7	3	2	1	2	3	0	1
	Score 5	2	1	2	2	2	0	2	0	3	6	0	0	0	1	0	1	2	2	1	6	1	0	3	6	0	1
	Score 6	4	0	0	1	0	2	0	0	0	1	0	0	5	1	5	0	0	0	0	1	1	0	0	0	0	0
	Score 7	0	1	0	1	0	0	2	0	0	0	0	0	0	3	1	0	0	1	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Doctor	Score 1	1	3	5	1	3	3	0	5	0	2	3	3	3	0	0	2	4	1	2	3	0	4	0	2	2	2
	Score 2	1	2	2	1	1	2	1	1	2	2	1	0	0	0	0	2	2	1	1	2	1	3	2	3	3	3
	Score 3	1	3	2	1	0	2	0	0	3	3	1	1	1	0	3	1	1	1	1	0	1	0	2	1	0	1
	Score 4	3	1	0	1	1	2	2	1	2	0	1	0	1	0	3	3	1	1	1	2	0	1	2	1	2	0
	Score 5	2	0	0	1	1	0	1	0	0	0	0	2	1	0	0	0	6	2	2	1	0	0	1	1	0	0
	Score 6	1	0	0	2	2	0	0	0	0	0	1	1	1	1	1	0	0	2	1	0	0	0	1	6	1	2
	Score 7	0	0	0	2	1	0	1	0	0	0	0	0	0	2	1	0	0	0	0	0	1	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital B Manager	Score 1	3	2	2	0	1	1	0	4	2	0	0	1	1	0	1	2	1	1	3	2	0	6	2	2	2	0
	Score 2	2	4	3	1	1	1	0	0	2	3	3	2	1	0	0	2	3	1	1	2	0	0	3	2	1	2
	Score 3	1	0	0	2	0	0	0	1	0	0	1	1	1	0	2	1	1	1	1	0	0	0	1	2	0	0
	Score 4	0	0	0	2	2	1	0	1	2	3	1	0	0	0	1	0	1	1	0	1	0	0	0	0	2	1
	Score 5	0	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	2
	Score 6	0	0	0	0	0	2	0	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Manager	Score 1	7	4	6	2	2	2	1	5	3	2	0	0	2	0	0	5	7	0	2	1	0	8	1	2	2	1
	Score 2	3	4	2	3	1	1	1	3	6	6	4	2	3	0	0	0	1	1	2	6	1	1	6	5	4	3
	Score 3	2	2	3	2	4	5	0	2	2	3	2	4	1	2	3	4	1	0	3	3	2	2	3	2	3	2
	Score 4	0	1	1	5	2	2	0	0	2	0	4	5	2	0	3	1	2	2	4	0	1	0	1	1	4	4
	Score 5	0	1	1	1	2	2	2	0	0	2	2	1	3	2	1	2	0	0	0	1	1	0	1	2	0	3
	Score 6	1	1	0	0	2	1	0	3	0	0	1	1	2	0	5	1	2	2	1	2	0	1	1	1	0	0
	Score 7	0	0	0	0	0	0	2	0	0	0	0	0	0	1	1	0	0	2	1	0	2	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Stage 3 of Questionnaire Survey: Summary of Responses from Hospitals A and B

		q2ad	q2ae	q2af	q2ag	q2ah	q2aj	q2ak	q2am	q2an	q3aM	q3aC	q3aT	q3aN	q3bM	q3bC	q3bT	q3bN	q3cM	q3cC	q3cT	q3cN	q4a	q4b	q4c	q4d	q4e
Sample Mean		3.62	5.92	2.60	3.03	2.53	2.62	2.62	2.26	4.31	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	2.43	2.31	2.50	2.60	2.50
Sample Standard Deviation		1.82	1.26	1.95	1.62	1.58	1.76	1.98	1.39	2.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.55	0.68	0.83	0.54	0.50
Hospital B Mean		3.72	6.75	3.26	3.16	2.58	2.67	2.61	2.11	4.67	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	2.40	2.25	2.55	2.45	2.56
Hospital B Standard Deviation		1.87	0.50	2.06	1.42	1.46	1.75	1.75	1.32	1.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.79	0.88	0.50	0.51
Hospital A Mean		3.52	5.56	2.38	2.90	2.48	2.57	3.00	2.38	4.20	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	2.45	2.36	2.45	2.73	2.62
Hospital A Standard Deviation		1.81	1.33	1.77	1.81	1.72	1.80	1.84	1.47	2.35	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.51	0.58	0.80	0.46	0.50
Hospital B	Score 1	3	0	5	3	6	6	7	9	0	3	4	3	15	7	4	9	8	8	5	7	8	1	4	2	1	0
	Score 2	2	0	5	3	4	4	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	10	7	5	9	8
	Score 3	4	0	0	6	4	4	2	4	6	0	0	0	0	0	0	0	0	0	0	0	0	9	9	13	10	11
	Score 4	2	0	3	2	2	0	4	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	2	0	2	5	3	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	5	1	3	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	3	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A	Score 1	2	6	10	8	8	7	4	7	2	11	7	7	8	8	6	9	8	8	10	10	8	0	1	1	0	0
	Score 2	8	0	3	5	4	7	6	7	1	0	0	0	0	0	0	0	0	0	0	0	0	12	12	10	6	8
	Score 3	4	1	3	3	3	2	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	10	9	11	15	13
	Score 4	2	0	3	2	0	1	2	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	3	4	0	2	4	3	3	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	3	1	1	3	1	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	1	3	1	0	0	1	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Score 1	5	0	15	9	15	13	11	16	2	14	11	10	23	13	10	16	16	13	15	17	14	1	5	3	1	0
	Score 2	8	0	6	8	8	11	9	9	1	0	0	0	0	0	0	0	0	0	0	0	0	22	19	15	15	16
	Score 3	8	1	3	9	7	6	8	6	9	0	0	0	0	0	0	0	0	0	0	0	0	16	18	24	26	24
	Score 4	4	0	8	4	2	1	8	5	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	5	4	2	7	7	4	4	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	3	2	4	3	1	3	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	1	0	2	0	0	1	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
tal Hospital B Doctor Mean		3.69	6.75	3.23	3.15	2.38	2.92	2.77	2.00	4.67	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	2.47	2.33	2.73	2.60	2.47
tal Hospital A Doctor Mean		2.63	6.67	2.88	3.38	2.75	2.75	2.50	1.75	4.00	1.00	#DIV/0!	1.00	1.00	#DIV/0!	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	2.22	2.44	2.33	2.56	2.50
l Hospital B Manager Mean		3.80	#DIV/0!	3.33	3.17	3.00	2.00	2.20	2.40	#DIV/0!	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	2.20	2.00	2.00	2.00	3.00
l Hospital A Manager Mean		4.08	5.00	2.08	2.62	2.31	2.46	3.31	2.77	4.33	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	2.62	2.31	2.54	2.85	2.69
Hospital B Doctor	Score 1	3	0	4	2	4	4	5	7	0	2	2	2	12	5	2	6	7	5	3	5	7	1	3	1	0	0
	Score 2	0	0	3	1	3	3	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	6	4	2	6	8
	Score 3	4	0	0	6	4	2	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	8	8	12	9	7
	Score 4	1	0	2	1	1	0	3	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	1	0	1	3	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	4	1	2	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	3	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Doctor	Score 1	2	0	2	2	4	3	2	4	1	2	0	1	7	0	1	1	7	6	3	2	4	0	0	1	0	0
	Score 2	3	0	3	1	1	2	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	7	5	4	4	4
	Score 3	1	0	0	2	0	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2	4	4	5	4
	Score 4	0	0	2	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	2	0	0	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	1	0	2	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	2	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital B Manager	Score 1	0	0	1	1	2	2	2	2	6	1	2	1	3	2	2	3	1	3	2	2	1	0	1	1	1	0
	Score 2	2	0	2	2	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	4	3	3	3	0
	Score 3	0	0	0	0	0	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	4
	Score 4	1	0	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	1	0	1	2	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Manager	Score 1	0	0	8	4	5	4	2	3	1	9	7	6	1	8	5	8	1	5	7	8	2	0	1	0	0	0
	Score 2	3	0	0	4	3	5	3	5	1	0	0	0	0	0	0	0	0	0	0	0	0	5	7	6	2	4
	Score 3	3	1	3	1	3	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	5	7	11	9
	Score 4	2	0	1	2	0	1	2	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	1	4	0	1	2	1	3	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	3	0	1	1	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	1	1	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Stage 3 of Questionnaire Survey: Summary of Responses from Hospitals A and B

		q4f	q4g	q4n	q4j	q4k	q4m	q4n	q5c	q5e	Q7	q8a_Con	q8a_Nur	q8a_Man	q8a_ChEx	q8a_TB	q8a_Pur	q8a_Oth	q8b_Con	q8b_Nur	q8b_Man	q8b_ChEx	q8b_TB	q8b_Pur	q8b_Oth	q8c_Con	q8c_Nur
Sample Mean		3.00	2.61	2.12	2.44	2.53	2.61	2.00	3.41	3.39	1.85	1.00	#DIV/0!	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	#DIV/0!	1.00	#DIV/0!
Sample Standard Deviation		0.00	0.45	0.86	0.65	0.74	0.56	0.00	1.14	1.09	0.94	0.00	#DIV/0!	0.00	0.00	0.00	0.00	0.00	0.00	#DIV/0!	0.00	0.00	0.00	#DIV/0!	0.00	#DIV/0!
Hospital B Mean		#DIV/0!	2.61	2.10	2.36	2.49	2.86	#DIV/0!	3.35	3.33	2.00	1.00	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	1.00	1.00	#DIV/0!	1.00	#DIV/0!
Hospital B Standard Deviation		#DIV/0!	0.51	0.83	0.86	0.81	0.48	#DIV/0!	1.09	1.11	0.97	0.00	#DIV/0!	0.00	0.00	0.00	0.00	#DIV/0!	#DIV/0!	#DIV/0!	0.00	0.00	#DIV/0!	0.00	#DIV/0!	#DIV/0!
Hospital A Mean		3.00	2.62	2.14	2.50	2.59	2.77	2.00	3.48	3.45	1.91	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!
Hospital A Standard Deviation		0.00	0.39	0.91	0.86	0.87	0.61	0.00	1.21	1.10	0.92	0.00	#DIV/0!	#DIV/0!	0.00	#DIV/0!	#DIV/0!	0.00	0.00	#DIV/0!	0.00	0.00	0.00	#DIV/0!	#DIV/0!	0.00	#DIV/0!
Hospital B	Score 1	0	1	6	5	4	1	0	1	1	8	9	0	2	4	2	10	0	1	1	8	12	1	2	0	10	0
	Score 2	0	2	7	3	3	1	0	4	5	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	18	6	13	14	19	0	4	3	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	8	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A	Score 1	0	0	7	5	2	2	0	1	2	10	4	0	0	14	0	1	3	2	0	7	11	2	0	0	7	0
	Score 2	0	4	4	1	5	1	2	5	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	3	18	10	18	15	19	0	2	3	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	9	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Score 1	0	1	13	10	6	3	0	2	3	19	13	0	2	10	2	11	3	3	1	15	23	3	2	0	17	0
	Score 2	0	6	11	4	6	2	2	9	6	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	3	36	16	29	29	38	0	6	5	17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	18	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	6	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ist Hospital B Doctor Mean		#DIV/0!	3.00	2.00	2.40	2.60	2.60	#DIV/0!	3.33	3.47	2.14	1.00	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	1.00	#DIV/0!
Ist Hospital A Doctor Mean		#DIV/0!	2.78	2.13	2.33	2.22	2.44	#DIV/0!	2.25	2.83	2.67	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!	#DIV/0!	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!
Hospital B Manager Mean		#DIV/0!	2.33	2.33	2.33	2.17	3.00	#DIV/0!	3.40	3.00	1.67	1.00	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!
Hospital A Manager Mean		3.00	2.65	2.15	2.62	2.85	3.00	2.00	4.23	4.00	1.38	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!
Hospital B Doctor	Score 1	0	0	5	3	2	1	0	1	1	8	7	0	1	3	1	6	0	0	0	5	10	1	2	0	5	0
	Score 2	0	0	5	3	2	1	0	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	15	5	9	11	13	0	2	3	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	8	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Doctor	Score 1	0	0	3	3	2	2	0	1	2	5	1	0	0	8	0	0	2	0	0	2	7	0	0	0	2	0
	Score 2	0	2	1	0	3	1	0	5	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	7	4	6	4	6	0	1	3	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital B Manager	Score 1	0	1	1	2	2	0	0	0	0	3	2	0	1	1	1	4	0	1	1	3	2	0	0	0	5	0
	Score 2	0	2	2	0	1	0	0	1	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	3	3	4	3	6	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Manager	Score 1	0	0	4	2	0	0	0	0	0	9	3	0	0	8	0	1	1	2	0	5	4	2	0	0	5	0
	Score 2	0	2	3	1	2	0	2	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	3	11	6	10	11	13	0	1	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Stage 3 of Questionnaire Survey: Summary of Responses from Hospitals A and B

		q8c_Man	q8c_ChEx	q8c_TB	q8c_Pur	q8c_Oth	q8d_Con	q8d_Nur	q8d_Man	q8d_ChEx	q8d_TB	q8d_Pur	q8d_Oth	q8e_Con	q8e_Nur	q8e_Man	q8e_ChEx	q8e_TB	q8e_Pur	q8e_Oth	q8f_Con	q8f_Nur	q8f_Man	q8f_ChEx	q8f_TB	q8f_Pur	q8f_Oth
Sample Mean		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	#DIV/0!	1.00	#DIV/0!	1.00	#DIV/0!	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!
Sample Standard Deviation		0.00	0.00	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00	0.00	0.00	#DIV/0!	0.00	0.00	0.00	0.00	0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00	#DIV/0!
Hospital B Mean		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!	1.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!
Hospital B Standard Deviation		#DIV/0!	0.00	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00	0.00	#DIV/0!	#DIV/0!	#DIV/0!	0.00	0.00	0.00	#DIV/0!	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00	#DIV/0!
Hospital A Mean		1.00	1.00	1.00	#DIV/0!	1.00	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	1.00	1.00	#DIV/0!	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!
Hospital A Standard Deviation		0.00	0.00	0.00	#DIV/0!	0.00	#DIV/0!	#DIV/0!	0.00	0.00	0.00	#DIV/0!	0.00	0.00	#DIV/0!	0.00	0.00	#DIV/0!	#DIV/0!	#DIV/0!	0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Hospital B	Score 1	1	8	2	1	3	1	2	10	10	1	1	0	10	2	8	0	0	4	0	19	0	0	0	0	2	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A	Score 1	4	6	3	0	2	0	1	11	4	2	0	4	12	0	7	2	0	0	0	20	0	1	0	0	1	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Score 1	5	14	5	1	5	1	3	21	14	3	1	4	22	2	13	2	0	4	0	39	0	1	0	0	3	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
tal Hospital B Doctor Mean		1.00	1.00	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	1.00	1.00	#DIV/0!	1.00	1.00	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!	1.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!
tal Hospital A Doctor Mean		1.00	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!	#DIV/0!	1.00	1.00	1.00	#DIV/0!	1.00	1.00	#DIV/0!	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!	1.00	#DIV/0!	#DIV/0!	1.00	#DIV/0!
l Hospital B Manager Mean		#DIV/0!	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!
l Hospital A Manager Mean		1.00	1.00	1.00	#DIV/0!	1.00	#DIV/0!	1.00	1.00	1.00	1.00	#DIV/0!	1.00	1.00	#DIV/0!	1.00	1.00	#DIV/0!	#DIV/0!	#DIV/0!	1.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Hospital B Doctor	Score 1	1	8	2	1	3	0	1	7	6	1	1	0	5	1	4	0	0	4	0	14	0	0	0	0	1	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Doctor	Score 1	1	5	0	0	1	0	0	2	2	1	0	2	1	0	5	1	0	0	0	7	0	1	0	0	1	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital B Manager	Score 1	0	2	0	0	0	1	1	3	4	0	0	0	0	5	1	2	0	0	0	5	0	0	0	0	1	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital A Manager	Score 1	3	1	3	0	1	0	1	9	2	1	0	2	11	0	2	1	0	0	0	13	0	0	0	0	0	0
	Score 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Score 8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 3 Database for Chapter 10: Trust Performance

	A	B	C	D	E	F	G	H	I	J	P	Q	R
1		Retained Surplus									£k	£k	£k
2	NAME	as % of	FTP Ranking	FTP Rank	FTP %	FTP %	Region	WAVE	Trust Type	No.	TOTAL INCOME	CORE INCOME	OTHER INCOME
3		Income	1994/95	993/9	993/9	994/95					Mar 95	Mar 95	Mar 95
4											1994/95	1994/95	1994/95
5													
6	ADDENBROOKE'S	+1.19%	276	76	8.5	6	AO	3	2	1	134,778	106,855	27,923
7	AIREDALE	+0.50%	288	169	6.7	6	NY	2	2	2	60,350	56,774	3,576
8	ALEXANDRA	+0.34%	0		349	5.7	WM	4	2	3	32,793	29,108	3,685
9	BARNSLEY DISTRICT GENERAL HOSPITAL	+1.45%	217	138	7.2	6.2	T	3	2	4	50,134	44,932	5,202
10	BASILDON & THURROCK GENERAL HOSPITALS	+1.98%	137	150	6.9	6.7	NT	2	2	5	68,720	56,649	12,071
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	+0.34%	331	166	6.7	5.9	T	2	2	6	35,415	33,539	1,876
12	BEDFORD HOSPITAL	+0.25%	189	63	9	6.4	AO	2	2	7	43,393	40,411	2,982
13	BIRMINGHAM HEARTLANDS HOSPITAL	+3.11%	28	60	9	11.2	WM	2	2	8	87,434	76,820	10,614
14	BISHOP AUCKLAND HOSPITALS	+0.22%	125			6.8	NY	4	2	9	32,378	29,745	2,633
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	+2.24%	51			8.7	NW	4	2	10	73,067	66,109	6,958
16	BOLTON HOSPITALS	+0.93%	64			8.3	NW	4	2	11	75,411	71,167	4,244
17	BRADFORD HOSPITALS	+0.00%	71	50	9.4	8.2	NY	1	2	12	99,283	92,117	7,166
18	BRIGHTON	+0.54%	282	167	6.7	6	ST	3	2	13	82,884	79,703	3,181
19	BROADGREEN HOSPITAL	+0.73%	258	263	5.5	6.1	NW	1	2	14	38,517	31,569	6,948
20	BROMLEY HOSPITALS	+1.14%	357	149	6.9	5.6	ST	3	2	15	65,647	60,940	4,707
21	BURTON HOSPITALS	+1.51%	227	24	13.1	6.2	WM	3	2	16	47,558	42,721	4,837
22	CARLISLE HOSPITALS	+0.12%	69			8.3	NY	4	2	17	43,164	39,304	3,860
23	CENTRAL MIDDLESEX HOSPITAL	+1.00%	328	140	7.2	5.9	NT	1	2	18	47,255	41,073	6,182
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	+0.02%	219	179	6.6	6.2	T	2	2	19	127,237	95,025	32,212
25	CHASE FARM HOSPITALS	+0.73%	305	109	7.8	6	NT	3	2	20	47,197	39,638	7,559
26	CHELSEA & WESTMINSTER	+0.44%	173			6.5	NT	4	2	21	96,230	73,397	22,833
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	+1.33%	315	100	8	6	T	3	2	22	56,295	50,151	6,144
28	CITY HOSPITAL	+2.53%	43			9.1	WM	4	2	23	86,201	74,211	11,990
29	CITY HOSPITAL SUNDERLAND	+1.28%	90			7.6	NY	4	2	24	100,799	92,420	8,379
30	CRAWLEY HORSHAM	-2.64%	416	157	6.8	0.1	ST	3	2	25	43,650	41,241	2,409
31	DARLINGTON MEMORIAL HOSPITAL	+2.27%	74			8.1	NY	4	2	26	40,580	34,623	5,957
32	DARTFORD AND GRAVESHAM	+0.91%	262			6.1	ST	4	2	27	54,358	50,801	3,557
33	DERBY CITY GENERAL HOSPITAL	+0.04%	400	124	7.6	4.3	T	3	2	28	46,712	42,415	4,297
34	DERBYSHIRE ROYAL INFIRMARY	+1.42%	92			7.5	T	4	2	29	74,497	66,743	7,754
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	+1.65%	214	216	6.2	6.2	T	1	2	30	71,324	64,253	7,071
36	DUDLEY GROUP OF HOSPITALS	+2.14%	151			6.6	WM	4	2	31	85,308	78,739	6,569
37	EALING HOSPITAL	+0.57%	202	160	6.7	6.3	NT	2	2	32	43,834	36,640	7,194
38	EAST HERFORDSHIRE	+0.98%	237	175	6.6	6.1	NT	2	2	33	59,742	55,583	4,159
39	EAST YORKSHIRE HOSPITALS	+0.10%	389	43	10.2	4.9	NY	3	2	34	41,512	38,619	2,893
40	EASTBOURNE HOSPITALS	+0.54%	338	185	6.5	5.8	ST	2	2	35	64,038	53,595	10,443
41	EPSOM	+0.01%	239	57	9.1	6.1	ST	1	2	36	48,381	42,731	5,650
42	FREEMAN GROUP OF HOSPITALS	+1.21%	264	227	6.1	6.1	NY	1	2	37	92,544	82,506	10,038
43	FRIMLEY PARK HOSPITAL	-0.08%	230	114	7.7	6.1	ST	2	2	38	49,656	44,971	4,685
44	FURNESS HOSPITALS	+0.66%	199			6.3	NW	4	2	39	31,892	30,103	1,789
45	GATESHEAD HOSPITALS	+1.09%	337	203	6.3	5.8	NY	3	2	40	44,500	39,360	5,140
46	GEORGE ELIOT HOSPITAL	+0.25%	48			8.8	WM	4	2	41	40,597	35,841	4,756
47	GLENFIELD HOSPITAL	+0.47%	311	75	8.5	6	T	3	2	42	50,849	44,936	5,913
48	GLOUCESTERSHIRE ROYAL	+1.12%	257	198	6.4	6.1	SW	3	2	43	67,910	62,051	5,859
49	GOOD HOPE HOSPITAL	+0.39%	380	250	6	5.1	WM	3	2	44	47,492	42,590	4,902
50	GUY'S AND ST THOMAS' HOSPITAL	+0.53%	96	79	8.4	7.4	ST	3	2	45	256,324	174,555	81,769
51	HALTON GENERAL HOSPITAL	+1.39%	334	241	6	5.9	NW	3	2	46	21,708	20,104	1,604
52	HAMMERSMITH HOSPITALS	+1.61%	117			6.9	NT	4	2	47	207,562	98,806	108,756
53	HARTLEPOOL AND PETERLEE HOSPITALS	+2.91%	42			9.1	NY	4	2	48	37,477	33,930	3,547
54	HAVERING HOSPITALS	+1.96%	354	26	12.6	5.6	NT	3	2	49	94,053	80,765	13,288
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS	+1.18%	144	233	6.1	6.7	AO	2	2	50	73,421	68,629	4,792
56	HEREFORD HOSPITALS	+1.33%	155			6.6	WM	4	2	51	36,941	32,550	4,391
57	HILLINGDON HOSPITAL	+1.56%	240	92	8.1	6.1	NT	1	2	52	52,510	47,121	5,389
58	HINCHINGBROKE	-1.63%	205	254	5.9	6.2	AO	3	2	53	39,013	37,118	1,895
59	HORTON GENERAL HOSPITAL	+0.21%	392	77	8.4	4.8	AO	3	2	54	19,560	17,689	1,871
60	IPSWICH HOSPITAL	+0.20%	374	219	6.2	5.2	AO	3	2	55	70,224	64,745	5,479
61	JAMES PAGET HOSPITAL	+0.94%	193	84	8.3	6.3	AO	3	2	56	54,212	50,991	3,221
62	KENT & CANTERBURY HOSPITALS	+1.05%	210	264	5.4	6.2	ST	3	2	57	54,205	49,397	4,808
63	KENT AND SUSSEX WEALD	+2.13%	53			8.7	ST	4	2	58	47,865	41,292	6,573
64	KETTERING GENERAL HOSPITAL	+2.18%	77			8	AO	4	2	59	48,539	42,673	5,866
65	KING'S	+0.74%	309	248	6	6	ST	3	2	60	138,536	108,497	30,039
66	KING'S LYNN & WISBECH HOSPITALS	+0.34%	362	252	6	5.5	AO	2	2	61	53,840	49,382	4,458
67	KINGSOTN HOSPITAL	+0.15%	190	281	4.1	6.3	ST	1	2	62	45,612	41,213	4,399
68	LANCASTER ACUTE HOSPITALS	+0.89%	132	205	6.3	6.8	NW	2	2	63	42,740	38,654	4,086
69	LEICESTER GENERAL HOSPITAL	+1.70%	148	88	8.2	6.6	T	3	2	64	63,380	54,550	8,830
70	LEICESTER ROYAL INFIRMARY	+0.83%	298	168	6.7	6	T	3	2	65	117,975	90,778	27,197
71	LEWISHAM HOSPITAL	+0.02%	124	130	7.4	6.8	ST	3	2	66	64,354	53,236	11,118
72	LINCOLN HOSPITALS	-0.44%	0		369	5.3	T	4	2	67	57,879	52,023	5,856
73	LOUTH AND DISTRICT	-0.18%	396			4.6	T	4	2	68	14,042	13,458	584
74	LUTON AND DUNSTABLE HOSPITAL	+1.75%	81	184	6.5	7.9	AO	2	2	69	55,440	50,363	5,077
75	MAYDAY	+0.99%	158	144	7	6.6	ST	3	2	70	65,796	60,999	4,797
76	MEDWAY	+0.65%	91			7.5	ST	4	2	71	58,145	50,326	7,819
77	MID CHESHIRE HOSPITALS	+2.58%	134	282	3.9	6.7	NW	1	2	72	54,897	50,198	4,699
78	MID ESSEX HOSPITALS	+0.49%	272	247	6	6	NT	2	2	73	65,749	59,106	6,643
79	MID KENT	+0.76%	269	113	7.7	6	ST	3	2	74	58,385	53,239	5,146
80	MID STAFFORDSHIRE GENERAL HOSPITALS	+0.58%	379	29	12.1	5.1	WM	3	2	75	56,112	48,344	7,768
81	MILTON KEYNES GENERAL	+1.00%	316	269	5.1	6	AO	2	2	76	41,200	40,090	1,110

	A	B	C	D	E	F	G	H	I	J	P	Q	R
1		Retained Surplus									£k	£k	£k
2	NAME	as % of	FTP Ranking	FTP Rank	FTP %	FTP %	Region	WAVE	Trust Type	No.	TOTAL INCOME	CORE INCOME	OTHER INCOME
3		Income	1994/95	993/9	993/9	994/95					Mar 95	Mar 95	Mar 95
4											1994/95	1994/95	1994/95
5													
82	MOUNT VERNON & WATFORD HOSPITALS	+0.00%	377			5.2	NT	4	2	77	78,719	66,890	11,829
83	NEWHAM	+0.76%	172			6.5	NT	4	2	78	53,585	44,484	9,1D1
84	NORFOLK & NORWICH	+1.18%	4			31.8	AO	4	2	79	113,025	104,233	8,792
85	NORTH DURHAM ACUTE HOSPITALS	+1.93%	22			12.7	NY	4	2	80	56,1D7	51,410	4,697
86	NORTH HAMPSHIRE HOSPITALS	+0.63%	129			6.8	SW	4	2	81	44,900	38,500	6,400
87	NORTH MIDDLESEX HOSPITAL	+0.01%	194	224	6.1	6.3	NT	1	2	82	54,464	46,226	8,238
88	NDRTH STAFFORDSHIRE HOSPITAL	+1.08%	329	64	9	5.9	WM	3	2	83	128,744	117,050	11,694
89	NORTHAMPTON GENERAL HOSPITAL	+1.90%	63			8.3	AO	4	2	84	69,756	65,834	3,922
90	NORTHERN GENERAL HOSPITAL	+0.00%	136	103	7.9	6.7	T	1	2	85	117,138	98,823	18,315
91	NORTHWICK PARK & ST MARK'S	+1.27%	238	243	6	6.1	NT	3	2	86	79,620	58,1D5	21,515
92	NOTTINGHAM CITY HOSPITAL	+0.00%	180	246	6	6.4	T	2	2	87	113,214	103,530	9,684
93	OXFORD RADCLIFFE HOSPITAL	+0.50%	2D8			6.2	A0	4	2	88	136,437	106,105	30,332
94	PETERBOROUGH HOSPITALS	+0.30%	281	10	181	6	AO	3	2	89	62,424	55,820	6,604
95	PILGRIM HEALTH	+1.51%	78			8	T	4	2	9D	48,171	42,936	5,235
96	PINDERFIELDS HOSPITALS	+0.20%	390	127	7.5	4.9	NY	3	2	91	63,359	54,172	9,187
97	PLYMOUTH HOSPITALS	+1.79%	40			9.6	SW	4	2	92	111,807	103,964	7,843
98	PONTEFRACT HOSPITALS	+0.62%	253	80	8.3	6.1	NY	3	2	93	39,736	36,712	3,D24
99	POOLE HOSPITAL	-0.37%	342	197	6.4	5.8	SW	2	2	94	60,826	53,411	7,415
100	PORTSMOUTH HOSPITALS	+0.67%	320	207	6.3	6	SW	4	2	95	134,382	101,694	32,688
101	PRESTON ACUTE HOSPITALS	+1.76%	113			7	NW	4	2	96	88,878	78,041	10,837
102	PRINCESS ROYAL HOSPITAL	+1.08%	401	1D7	7.8	4.3	WM	3	2	97	28,230	25,721	2,509
103	QUEEN MARY'S SIDCUP	+0.15%	387	146	7	5	ST	3	2	98	43,831	4D,156	3,675
104	QUEEN VICTORIA HOSPITAL	+1.19%	345			5.7	ST	4	2	99	14,664	13,590	1,074
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	+1.24%	261	82	8.3	6.1	T	3	2	100	123,468	99,658	23,810
106	RADCLIFFE INFIRMARY	+1.00%	228	101	7.9	6.2	AO	3	2	101	34,425	28,328	6,097
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	+0.53%	195			6.3	WM	4	2	102	21,018	18,581	2,437
108	ROCHDALE	+0.69%	223	189	6.5	6.2	NW	2	2	103	7D,735	57,855	12,880
109	ROTHERHAM GENERAL HOSPITALS	+1.41%	147	274	4.9	6.6	T	3	2	104	64,057	57,621	6,436
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	+0.79%	350	158	6.8	5.6	AO	3	2	105	86,413	79,146	7,267
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	+0.79%	274	190	6.5	6	SW	2	2	106	70,757	66,520	4,237
112	RDYAL BROMPTON HOSPITAL	+1.17%	322			6	NT	4	2	107	56,855	18,428	38,427
113	ROYAL CORNWALL HOSPITALS	+0.23%	284	193	6.4	6	SW	2	2	108	81,488	73,139	8,349
114	ROYAL DEVON ANO EXETER	+0.07%	70			8.3	SW	3	2	109	94,972	84,565	10,407
115	ROYAL FREE HAMPSTEAD	+0.69%	157	192	6.4	6.6	NT	1	2	110	126,940	100,415	26,525
116	ROYAL HULL HOSPITALS	+0.15%	326	187	6.5	6	NY	3	2	111	101,205	93,764	7,441
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	+0.90%	299	285	3.6	6	NW	1	2	112	103,546	83,788	19,758
118	ROYAL SHREWSBURY HOSPITALS	+0.68%	370			5.2	WM	4	2	113	55,926	50,764	5,162
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	+0.03%	386	237	6	5	ST	1	2	114	54,419	48,599	5,820
120	ROYAL UNITED HOSPITAL BATH	-3.77%	410	272	5	2	SW	2	2	115	67,518	59,494	8,D24
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	+1.23%	66			8.3	NY	4	2	116	162,577	134,153	28,424
122	ROYAL WEST SUSSEX	-0.68%	395			4.6	ST	4	2	117	39,691	35,288	4,403
123	ROYAL WOLVERHAMPTON HOSPITALS	+1.38%	101			7.3	WM	4	2	118	83,819	73,369	10,450
124	SALFORD ROYAL HOSPITALS	+1.88%	44			9.1	NW	4	2	119	83,417	66,754	16,663
125	SCUNTHORPE & GOOLE HOSPITALS	+1.54%	236	253	5.9	6.1	NY	3	2	120	50,581	45,630	4,951
126	SOUTH KENT HOSPITALS	+1.76%	0				ST	4	2	121	65,229	57,621	7,608
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	+0.33%	105			7.2	NW	4	2	122	148,813	130,727	18,086
128	SOUTH TEES ACUTE HOSPITALS	-0.09%	384	235	6	5	NY	3	2	123	1D7,576	96,221	11,355
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	-2.19%	399	289	0.2	4.4	WM	3	2	124	42,989	36,682	6,307
130	SOUTHAMPTON UNIVERSITY HOSPITALS	+0.54%	234	255	5.9	6.1	SW	3	2	125	163,761	130,153	33,608
131	SOUTHEND	-1.59%	133	199	6.4	6.7	NT	1	2	126	68,195	61,863	6,332
132	SOUTHPORT AND FORMBY	+1.36%	273	213	6.2	6	NW	2	2	127	36,881	33,146	3,735
133	ST ALBANS AND HEMEL HEMPSTEAD	+0.51%	279			6	NT	4	2	128	52,685	45,481	7,204
134	ST GEORGE'S	+0.33%	343	126	7.5	5.8	ST	3	2	129	143,092	103,337	39,755
135	ST HELENS AND KNOWSLEY HOSPITALS	+0.66%	183	131	7.3	6.4	NW	1	2	130	87,362	79,346	8,D16
136	ST HELIER	+2.21%	47	120	7.6	8.8	ST	1	2	131	86,752	77,386	9,366
137	ST JAMES'S UNIVERSITY HOSPITAL	+0.02%	220	136	7.3	6.2	NY	1	2	132	131,104	111,979	19,125
138	ST MARY'S (IoW)	+0.60%	391	173	6.6	4.9	SW	3	2	133	36,285	31,208	5,077
139	ST MARY'S	+0.68%	360	23D	6.1	5.5	NT	3	2	134	111,651	88,502	23,149
140	STOCKPORT ACUTE SERVICES	+0.47%	102			7.3	NW	4	2	135	54,199	42,621	11,578
141	STOKE MANDEVILLE HOSPITAL	+1.77%	34			10.2	AO	4	2	136	54,321	50,413	3,908
142	SWINDON AND MARLBOROUGH	-0.82%	409			2.8	SW	4	2	137	63,347	57,830	5,517
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	+2.89%	45			9	NW	4	2	138	43,9D5	37,766	6,139
144	THANET	+0.23%	186	45	10	6.4	ST	3	2	139	36,368	33,408	2,960
145	UNITED LEEDS TEACHING HOSPITALS	-0.21%	356	257	5.8	5.6	NY	1	2	140	158,801	130,297	28,504
146	UNIVERSITY COLLEGE LONDON HOSPITALS	+1.20%	119			6.9	NT	4	2	141	142,490	105,090	37,400
147	WALSALL HOSPITALS	+1.92%	88	51	9.3	7.6	WM	1	2	142	61,918	56,600	5,318
148	WALSGRAVE HOSPITALS	+0.35%	385	271	5	5	WM	3	2	143	102,916	93,303	9,613
149	WARRINGTON HOSPITAL	+0.65%	294	270	5.1	6	NW	3	2	144	48,570	44,559	4,011
150	WEST DORSET GENERAL HOSPITALS	+0.21%	321	17B	6.6	6	SW	1	2	145	42,404	38,137	4,267
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	+0.60%	324	132	7.3	6	NT	3	2	146	50,157	42,688	7,469
152	WEST SUFFOK HOSPITALS	+0.96%	268	151	6.9	6	AO	3	2	147	49,755	45,651	4,104
153	WESTMORLAND HOSPITALS	+3.36%	128	260	5.5	6.8	NW	3	2	148	16,447	15,952	495
154	WHITTINGTON HOSPITAL	+1.29%	368	99	8	5.3	NT	3	2	149	68,317	54,208	14,109
155	WINCHESTER & EASTLEIGH	+1.14%	121			6.8	SW	4	2	150	61,819	58,376	3,443
156	WIRRAL HOSPITAL	+1.24%	150	125	7.5	6.6	NW	1	2	151	98,555	89,381	9,174
157	WORTHING & SOUTHLANDS HOSPITALS	+0.13%	67			8.3	ST	4	2	152	56,338	51,074	5,264

	A	S	T	U	V	W	X	Y	Z	AA	AB
1		£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
2	NAME	EXPENDITURE	Net Retained	Net Retained	Net Retained	Net Retained	Operating	Operating	Operating	Operating	CORE INCOME
3		Mar 95	Surplus	Surplus	Surplus	Surplus	Surplus	Surplus	Surplus	Surplus	Mar 92
4		1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92
5											
6	AODENBRDOKE'S	128,791			2,305	1,599	0	0	7,773	5,987	
7	AIREDALE	57,151	0	-577	0	300	0	2,092	3,420	3,199	
8	ALEXANDRA	31,230			0	112	0	0	0	1,563	
9	BARNSLEY DISTRICT GENERAL HOSPITAL	47,653			1,065	728	0	0	2,786	2,481	
10	BASILDON & THURROCK GENERAL HDSPITALS	63,617		2,935	1,343	1,363	0	6,410	5,004	5,103	
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	33,363		252	182	122	0	1,721	1,974	2,052	
12	BEDFORD HOSPITAL	41,717		626	1,057	107	0	1,633	2,379	1,676	
13	BIRMINGHAM HEARTLANDS HDSPITAL	80,569	0	668	1,671	2,718	0	3,853	5,147	6,865	
14	BISHOP AUCKLAND HDSPITALS	31,277				72	0	0	0	1,101	
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	68,599				1,635	0	0	0	4,468	
16	BOLTON HOSPITALS	71,402				704	0	0	0	4,009	
17	BRADFORD HOSPITALS	93,792	0	-1,312	0	0	3,764	3,114	5,114	5,491	76,432
18	BRIGHTON	80,371			556	447	0	0	2,560	2,513	
19	BROADGREEN HOSPITAL	36,476	-326	-3,079	-434	283	1,529	-741	1,908	2,041	32,798
20	BROMLEY HOSPITALS	61,650			794	748	0	0	4,824	3,997	
21	BURTON HOSPITALS	44,244			2,299	718	0	0	5,616	3,314	
22	CARLISLE HOSPITALS	41,587				52	0	0	0	1,577	
23	CENTRAL MIDDLESEX HOSPITAL	43,982	3,345	2,593	250	473	7,814	5,683	3,976	3,273	45,378
24	CENTRAL SHEFFIELD UNIVERSITY HDSPITALS	121,354		808	47	27	0	5,773	5,888	5,883	
25	CHASE FARM HOSPITALS	44,238			1,064	343	0	0	3,331	2,959	
26	CHELSEA & WESTMINSTER	83,685				426	0	0	0	12,545	
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	53,605			655	747	0	0	3,377	2,690	
28	CITY HOSPITAL	80,866				2,183	0	0	0	5,335	
29	CITY HOSPITAL SUNDERLAND	96,268				1,290	0	0	0	4,531	
30	CRAWLEY HORSHAM	43,612			249	-1,154	0	0	2,245	38	
31	DARLINGTON MEMORIAL HOSPITAL	38,153				921	-0	0	0	2,427	
32	DARTFORD AND GRAVESHAM	50,553				496	0	0	0	3,805	
33	DERBY CITY GENERAL HOSPITAL	45,066			1,268	19	0	0	2,672	1,646	
34	DERBYSHIRE ROYAL INFIRMARY	70,176				1,059	0	0	0	4,321	
35	DONCASTER RDYAL & MANDTAGU HOSPITAL	67,349	134	1,263	552	1,175	3,121	3,826	3,777	3,975	57,748
36	DUDLEY GROUP OF HOSPITALS	79,450				1,824	0	0	0	5,858	
37	EALING HOSPITAL	41,803		-594	548	252	0	928	2,158	2,031	
38	EAST HERFORDSHIRE	56,854		252	544	583	0	2,317	3,001	2,888	
39	EAST YORKSHIRE HOSPITALS	40,013			790	43	0	0	3,034	1,499	
40	EASTBOURNE HOSPITALS	60,410		50	812	344	0	3,025	3,994	3,628	
41	EPSOM	46,268	204	1,050	786	3	3,167	3,059	3,151	2,113	37,542
42	FREEMAN GROUP OF HOSPITALS	89,315	2,435	769	1,178	1,123	4,628	3,008	3,198	3,229	61,664
43	FRIMLEY PARK HOSPITAL	47,135		682	17	-39	0	-344,624	2,562	2,521	
44	FURNESS HOSPITALS	29,498				212	0	0	0	2,394	
45	GATESHEAD HOSPITALS	42,219			687	486	0	0	2,372	2,281	
46	GEORGE ELIOT HOSPITAL	37,186				103	0	0	0	3,411	
47	GLENFIELD HOSPITAL	47,584			414	240	0	0	3,976	3,265	
48	GLOUCESTERSHIRE ROYAL	64,654			647	758	0	0	3,153	3,256	
49	GOOD HOPE HOSPITAL	45,058			777	280	0	0	2,709	2,434	
50	GUY'S AND ST THOMAS' HOSPITAL	241,671			2,604	1,353	0	0	15,980	14,653	
51	HALTON GENERAI HOSPITAL	20,614			197	302	0	0	1,114	1,094	
52	HAMMERSMITH HOSPITALS	192,034				3,345	0	0	0	15,528	
53	HARTLEPOOL AND PETERLEE HOSPITALS	34,388				1,089	0	0	0	3,089	
54	HAVERING HOSPITALS	88,737			5,801	1,840	0	0	11,849	5,316	
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS	69,115		1,504	369	867	0	0	0	4,306	
56	HEREFORD HOSPITALS	35,244				492	0	0	0	1,697	
57	HILLINGDON HOSPITAL	49,628	1,554	873	1,926	820	3,919	2,759	3,667	2,882	41,729
58	HINCHINGBROKE	38,168			196	-655	0	0	1,726	845	
59	HORTON GENERAL HOSPITAL	18,575			373	41	0	0	1,626	985	
60	IPSWICH HOSPITAL	66,960			53	139	0	0	3,602	3,264	
61	JAMES PAGET HOSPITAL	52,368			972	511	0	0	2,333	1,844	
62	KENT & CANTERBURY HOSPITALS	51,877			198	569	0	0	1,926	2,328	
63	KENT AND SUSSEX WEALD	45,021				1,020	0	0	0	2,844	
64	KETTERING GENERAL HOSPITAL	45,707				1,060	0	0	0	2,832	
65	KING'S	133,995			220	1,022	0	0	3,879	4,541	
66	KING'S LYNN & WISBECH HOSPITALS	51,303		502	116	182	0	2,872	2,746	2,537	
67	KINGSOTN HOSPITAL	42,724	677	305	-1,044	70	4,456	3,771	1,849	2,888	38,656
68	LANCASTER ACUTE HOSPITALS	40,214		332	112	382	0	2,107	2,399	2,526	
69	LEICESTER GENERAL HOSPITAL	59,849			721	1,075	0	0	4,013	3,531	
70	LEICESTER ROYAL INFIRMARY	111,607			1,201	982	0	0	6,615	6,368	
71	LEWISHAM HOSPITAL	60,322			420	14	0	0	4,099	4,032	
72	LINCOLN HOSPITALS	55,404				-257	0	0	0	2,475	
73	LOUTH AND DISTRICT	13,624				-25	0	0	0	418	
74	LUTON AND DUNSTABLE HOSPITAL	52,287		1,572	-3,621	972	0	2,965	2,640	3,153	
75	MAYDAY	62,837			492	652	0	0	3,043	2,959	
76	MEDWAY	55,041				378	0	0	0	3,104	
77	MID CHESHIRE HOSPITALS	52,008	410	812	18	1,418	3,163	881	1,538	2,889	42,168
78	MID ESSEX HOSPITALS	61,782		2,067	-760	323	0	-507,712	3,972	3,967	
79	MID KENT	55,341			319	441	0	0	3,727	3,044	
80	MID STAFFORDSHIRE GENERAL HOSPITALS	53,268			2,941	325	0	0	6,495	2,844	
81	MILTON KEYNES GENERAL	38,232		510	-456	410	0	3,005	2,455	2,968	

	A	S	T	U	V	W	X	Y	Z	AA	AB
1		£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
2	NAME	EXPENDITURE	Net Retained	Net Retained	Net Retained	Net Retained	Operating	Operating	Operating	Operating	CORE INCOME
3		Mar 95	Surplus	Surplus	Surplus	Surplus	Surplus	Surplus	Surplus	Surplus	Mar 92
4		1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92
5											
82	MOUNT VERNON & WATFORD HOSPITALS	74,652				1	0	0	0	4,067	
83	NEWHAM	51,215				409	0	0	0	2,370	
84	NORFOLK & NORWICH	108,298				1,336	0	0	0	4,727	
85	NORTH DURHAM ACUTE HOSPITALS	53,343				1,081	0	0	0	2,764	
86	NORTH HAMPSHIRE HOSPITALS	43,423				281	0	0	0	1,477	
87	NORTH MIDDLESEX HOSPITAL	51,108	-425	1,020	723	7	2,426	3,604	3,257	3,356	43,579
88	NORTH STAFFORDSHIRE HOSPITAL	122,661			4,173	1,396	0	0	8,929	6,083	
89	NORTHAMPTON GENERAL HOSPITAL	65,139				1,328	0	0	0	4,617	
90	NORTHERN GENERAL HOSPITAL	109,972	5	4	6	5	4,998	5,885	7,286	7,166	84,066
91	NORTHWICK PARK & ST MARK'S	75,094			1,555	1,009	0	0	4,151	4,526	
92	NOTTINGHAM CITY HOSPITAL	105,618		22	68	5	0	4,620	6,783	7,596	
93	OXFORD RADCLIFFE HOSPITAL	130,175				684	0	0	0	6,262	
94	PETERBOROUGH HOSPITALS	60,716			2,238	186	0	0	5,044	1,708	
95	PILGRIM HEALTH	45,322				725	0	0	0	2,849	
96	PINDERFIELDS HOSPITALS	61,672			152	126	0	0	2,573	1,687	
97	PLYMOUTH HOSPITALS	104,546				2,000	0	0	0	7,261	
98	PONTEFRACT HOSPITALS	38,254			30	247	0	0	1,878	1,482	
99	POOLE HOSPITAL	58,231		754	88	-226	0	2,501	2,512	2,595	
100	PORTSMOUTH HOSPITALS	128,842				906	0	0	0	5,540	
101	PRESTON ACUTE HOSPITALS	83,190				1,560	0	0	0	5,688	
102	PRINCESS ROYAL HOSPITAL	26,863			901	304	0	0	2,357	1,367	
103	QUEEN MARY'S SIDCUP	42,029			64	66	0	0	2,390	1,802	
104	QUEEN VICTORIA HOSPITAL	14,088				174	0	0	0	576	
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	117,497			2,513	1,526	0	0	7,725	5,971	
106	RADCLIFFE INFIRMARY	32,276			894	345	0	0	2,519	2,149	
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	19,638				112	0	0	0	1,380	
108	ROCHDALE	67,685		1,116	535	485	0	3,470	3,178	3,050	
109	ROTHERHAM GENERAL HOSPITALS	59,611			285	905	0	0	2,951	4,446	
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	81,479			1,276	686	0	0	5,625	4,934	
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	66,542		1,543	636	560	0	4,715	4,387	4,215	
112	ROYAL BROMPTON HOSPITAL	53,281				665	0	0	0	3,574	
113	ROYAL CORNWALL HOSPITALS	77,535		299	592	185	0	3,322	3,869	3,953	
114	ROYAL DEVON AND EXETER	90,382			2,446	65	0	0	6,831	4,590	
115	ROYAL FREE HAMPSTEAD	119,928	769	765	1,128	1,119	6,525	6,195	6,748	7,012	78,684
116	ROYAL HULL HOSPITALS	98,578			403	155	0	0	2,753	2,627	
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	97,629	0	-2,800	-1,710	931	4,270	2,100	3,391	5,917	74,905
118	ROYAL SHREWSBURY HOSPITALS	54,440				383	0	0	0	1,486	
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	51,800	2,923	-1,215	633	19	6,243	805	3,114	2,619	44,886
120	ROYAL UNITED HOSPITAL BATH	66,049		-767	-676	-2,545	0	2,855	3,548	1,469	
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	155,179				2,005	0	0	0	7,398	
122	ROYAL WEST SUSSEX	38,149				-271	0	0	0	1,542	
123	ROYAL WOLVERHAMPTON HOSPITALS	78,722				1,154	0	0	0	5,097	
124	SALFORD ROYAL HOSPITALS	78,167				1,572	0	0	0	5,250	
125	SCUNTHORPE & GOOLE HOSPITALS	46,667			107	779	0	0	3,577	3,914	
126	SOUTH KENT HOSPITALS	61,225				1,148	0	0	0	4,004	
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	143,878				490	0	0	0	4,935	
128	SOUTH TEES ACUTE HOSPITALS	103,654				-97	0	4,508	4,481	3,922	
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	41,386			-1,546	-940	0	0	70	1,603	
130	SOUTHAMPTON UNIVERSITY HOSPITALS	155,435			478	878	0	0	7,850	8,326	
131	SOUTHEND	64,647	60	166	-1,139	-1,082	3,185	2,744	3,649	3,548	50,797
132	SOUTHPORT AND FORMBY	34,173		-347	481	502	0	2,107	2,749	2,708	
133	ST ALBANS AND HEMEL HEMPSTEAD	48,861				270	0	0	0	3,824	
134	ST GEORGE'S	135,942			1,863	468	0	0	8,754	7,150	
135	ST HELENS AND KNOWSLEY HOSPITALS	81,476	430	827	1,125	574	5,248	4,931	6,268	5,886	68,931
136	ST HELIER	81,448	348	1,401	668	1,917	3,888	4,657	4,234	5,304	65,057
137	ST JAMES'S UNIVERSITY HOSPITAL	126,476	209	-521	22	29	3,129	2,788	4,433	4,628	82,801
138	ST MARY'S (IoW)	33,983			369	218	0	0	3,052	2,302	
139	ST MARY'S	107,207			240	759	0	0	4,806	4,444	
140	STOCKPORT ACUTE SERVICES	51,955				257	0	0	0	2,244	
141	STOKE MANDEVILLE HOSPITAL	50,335				960	0	0	0	3,986	
142	SWINDON AND MARLBOROUGH	62,377				-522	0	0	0	970	
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	40,666				1,271	0	0	0	3,239	
144	THANET	35,132			251	82	0	0	1,814	1,236	
145	UNITED LEEDS TEACHING HOSPITALS	152,106	2,891	1,981	34	-334	7,889	5,900	6,314	6,695	109,483
146	UNIVERSITY COLLEGE LONDON HOSPITALS	134,995				1,704	0	0	0	7,495	
147	WALSALL HOSPITALS	57,344	2,281	-1,053	1,867	1,191	5,767	1,483	5,184	4,574	51,346
148	WALSGRAVE HOSPITALS	99,699			715	359	0	0	3,103	3,217	
149	WARRINGTON HOSPITAL	46,119			156	316	0	0	1,928	2,451	
150	WEST DORSET GENERAL HOSPITALS	40,151	689	620	187	91	36,757	37,759	40,003	2,253	34,077
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	47,310			104	299	0	0	3,498	2,847	
152	WEST SUFFOK HOSPITALS	47,682			528	478	0	0	2,105	2,073	
153	WESTMORLAND HOSPITALS	14,624			208	552	0	0	1,468	1,823	
154	WHITTINGTON HOSPITAL	65,438			1,678	880	0	0	4,237	2,879	
155	WINCHESTER & EASTLEIGH	58,605				706	0	0	0	3,214	
156	WIRRAL HOSPITAL	92,097	689	2,332	2,858	1,224	4,782	5,439	6,979	6,458	80,047
157	WORTHING & SOUTHLANDS HOSPITALS	53,330				73	0	0	0	3,008	

	A	AC	AD	AE	AF	AG	AH	AI	AJ	AK
1		£k	£k	£k	£k	£k	£k	£k	£k	£k
2	*NAME*	*CORE INCOME*	*CORE INCOME*	*CORE INCOME*	*OTHER INCOME*	*OTHER INCOME*	*OTHER INCOME*	*OTHER INCOME*	*TOTAL INCOME*	*TOTAL INCOME*
3		*Mar 93*	*Mar 94*	*Mar 95*	*Mar 92*	*Mar 93*	*Mar 94*	*Mar 95*	*Mar 92*	*Mar 93*
4		*1992/93*	*1993/94*	*1994/95*	*1991/92*	*1992/93*	*1993/94*	*1994/95*	*1991/92*	*1992/93*
5										
6	ADDENBROOKE'S		101,295	106,855			25,477	27,923	0	0
7	AIREDALE	52,244	54,507	56,774		3,076	2,889	3,576	0	55,320
8	ALEXANDRA			29,108				3,685	0	0
9	BARNSLEY DISTRICT GENERAL HOSPITAL		43,911	44,932			4,469	5,202	0	0
10	BASILDON & THURROCK GENERAL HOSPITALS	53,614	54,417	56,649		12,204	11,143	12,071	0	65,818
11	BASSETLAW HDSPITAL AND COMMUNITY SERVICES	30,979	32,056	33,539		409	1,092	1,876	0	31,388
12	BEDFORD HOSPITAL	32,261	37,906	40,411		2,628	3,550	2,982	0	34,889
13	BIRMINGHAM HEARTLANDS HOSPITAL	54,490	66,036	76,820		8,014	7,974	10,614	0	62,504
14	BISHOP AUCKLAND HOSPITALS			29,745				2,633	0	0
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY								0	0
16	BOLTON HOSPITALS								0	0
17	BRADFORD HOSPITALS	84,317	89,566	92,117	1,737	4,588	3,845	7,166	78,169	88,905
18	BRIGHTON		78,829	79,703			2,975	3,181	0	0
19	BROADGREEN HOSPITAL	34,690	32,527	31,569	5,789	7,328	8,811	6,948	38,587	42,018
20	BROMLEY HOSPITALS		61,214	60,940			4,834	4,707	0	0
21	BURTON HOSPITALS		41,978	42,721			5,035	4,837	0	0
22	CARLISLE HOSPITALS								0	0
23	CENTRAL MIDDLESEX HOSPITAL	46,673	42,041	41,073	2,845	2,743	6,299	6,182	48,223	49,416
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	93,447	92,289	95,025		19,419	29,491	32,212	0	112,866
25	CHASE FARM HOSPITALS		38,423	39,638			7,589	7,559	0	0
26	CHELSEA & WESTMINSTER								0	0
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI		49,361	50,151			5,911	6,144	0	0
28	CITY HDSPITAL								0	D
29	CITY HOSPITAL SUNDERLAND								0	0
30	CRAWLEY HORSHAM		41,595	41,241			2,180	2,409	0	0
31	DARLINGTON MEMORIAL HOSPITAL								0	0
32	DARTFORD AND GRAVESHAM								0	0
33	DERBY CITY GENERAL HOSPITAL		38,150	42,415			3,755	4,297	0	0
34	DERBYSHIRE RDYAL INFIRMARY								0	0
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	61,217	62,588	64,253	925	2,397	4,476	7,071	58,673	63,614
36	DUDLEY GRDUP OF HOSPITALS								0	0
37	EALING HOSPITAL	35,624	36,288	36,640		5,172	6,657	7,194	0	40,796
38	EAST HERFORDSHIRE	52,876	54,080	55,583		3,037	3,914	4,159	0	55,913
39	EAST YORKSHIRE HOSPITALS		37,980	38,619			2,246	2,893	0	0
40	EASTBOURNE HOSPITALS	49,886	52,389	53,595		7,091	9,133	10,443	0	56,977
41	EPSOM	42,304	41,218	42,731	6,040	5,225	6,285	5,650	43,582	47,529
42	FREEMAN GROUP OF HOSPITALS	67,587	68,841	82,506	6,840	6,839	8,837	10,038	68,504	74,426
43	FRIMLEY PARK HDSPITAL	39,021	41,741	44,971		2,044	3,168	4,685	0	41,065
44	FURNESS HOSPITALS								0	0
45	GATESHEAD HOSPITALS		36,764	39,360			4,830	5,140	0	0
46	GEORGE ELIOT HOSPITAL								0	0
47	GLENFIELD HOSPITAL		43,453	44,936			5,146	5,913	0	0
48	GLOUCESTERSHIRE ROYAL		58,231	62,051			6,018	5,859	0	0
49	GOOD HOPE HOSPITAL		39,059	42,590			4,221	4,902	0	0
50	GUY'S AND ST THOMAS' HOSPITAL		184,606	174,555			86,432	81,769	0	0
51	HALTON GENERAI HOSPITAL		19,498	20,104			1,567	1,604	0	0
52	HAMMERSMITH HOSPITALS								0	0
53	HARTLEPOOL AND PETERLEE HOSPITALS								0	0
54	HAVERING HOSPITALS		82,374	80,765			11,765	13,288	0	0
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS									
56	HEREFORD HOSPITALS								0	0
57	HILLINGDON HOSPITAL	44,380	44,363	47,121	4,810	5,544	6,951	5,389	46,539	49,924
58	HINCHINGBROKE		34,293	37,118			2,559	1,895	0	0
59	HORTON GENERAL HOSPITAL		17,655	17,689			1,736	1,871	0	0
60	IPSWICH HOSPITAL		60,945	64,745			4,481	5,479	0	0
61	JAMES PAGET HOSPITAL		37,736	50,991			3,060	3,221	0	0
62	KENT & CANTERBURY HOSPITALS		44,743	49,397			4,975	4,808	0	0
63	KENT AND SUSSEX WEALD								0	0
64	KETTERING GENERAL HOSPITAL								0	0
65	KING'S		101,482	108,497			41,016	30,039	0	0
66	KING'S LYNN & WISBECH HOSPITALS	45,967	46,737	49,382		4,004	4,798	4,458	0	49,971
67	KINGSDTN HDSPITAL	40,741	38,021	41,213	3,246	4,319	4,534	4,399	41,902	45,060
68	LANCASTER ACUTE HOSPITALS	37,645	38,258	38,654		4,278	3,662	4,086	0	41,923
69	LEICESTER GENERAL HOSPITAL		51,660	54,550			8,306	8,830	0	0
70	LEICESTER ROYAL INFIRMARY		86,094	90,778			22,636	27,197	0	0
71	LEWISHAM HOSPITAL		52,536	53,236			11,418	11,118	0	0
72	LINCOLN HOSPITALS								0	0
73	LOUTH AND DISTRICT								0	0
74	LUTON AND DUNSTABLE HOSPITAL	46,456	47,343	50,363		5,017	4,633	5,077	0	51,473
75	MAYDAY		58,766	60,999			5,509	4,797	0	0
76	MEDWAY								0	0
77	MID CHESHIRE HOSPITALS	45,577	48,465	50,198	2,652	2,303	4,097	4,699	44,820	47,880
78	MID ESSEX HOSPITALS	58,041	55,853	59,106		4,442	6,432	6,643	0	62,483
79	MID KENT		50,592	53,239			4,815	5,146	0	0
80	MID STAFFORDSHIRE GENERAL HOSPITALS		49,737	48,344			7,118	7,768	0	0
81	MILTON KEYNES GENERAL	36,181	37,823	40,090		730	753	1,110	0	36,911

	A	AC	AD	AE	AF	AG	AH	AI	AJ	AK
1		£k	£k	£k	£k	£k	£k	£k	£k	£k
2	NAME	CORE INCOME	CORE INCOME	CORE INCOME	OTHER INCOME	OTHER INCOME	OTHER INCOME	OTHER INCOME	TOTAL INCOME	TOTAL INCOME
3		Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93
4		1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93
5										
82	MOUNT VERNON & WATFORD HOSPITALS								0	0
83	NEWHAM								0	0
84	NORFOLK & NORWICH								0	0
85	NORTH DURHAM ACUTE HOSPITALS								0	0
86	NORTH HAMPSHIRE HOSPITALS								0	0
87	NORTH MIDDLESEX HOSPITAL	44,523	44,136	46,226	2,927	6,116	7,085	8,238	46,506	50,639
88	NORTH STAFFORDSHIRE HOSPITAL		112,752	117,050			12,708	11,694	0	0
89	NORTHAMPTON GENERAL HOSPITAL								0	0
90	NORTHERN GENERAL HOSPITAL	88,363	93,097	98,823	2,120	13,796	16,912	18,315	86,186	102,159
91	NORTHWICK PARK & ST MARK'S		47,571	58,105			19,515	21,515	0	0
92	NOTTINGHAM CITY HOSPITAL	78,461	92,343	103,530		13,070	14,340	9,684	0	91,531
93	OXFORD RADCLIFFE HOSPITAL								0	0
94	PETERBOROUGH HOSPITALS		54,539	55,820			6,246	6,604	0	0
95	PILGRIM HEALTH								0	0
96	PINDERFIELDS HOSPITALS		50,947	54,172			9,014	9,187	0	0
97	PLYMOUTH HOSPITALS								0	0
98	PONTEFRACT HOSPITALS		36,119	36,712			3,046	3,024	0	0
99	PODLE HOSPITAL	48,078	48,459	53,411		2,627	6,858	7,415	0	50,705
100	PORTSMOUTH HOSPITALS								0	0
101	PRESTON ACUTE HOSPITALS								0	0
102	PRINCESS ROYAL HOSPITAL		24,125	25,721			2,713	2,509	0	0
103	QUEEN MARY'S SIDCUP		39,819	40,156			3,181	3,675	0	0
104	QUEEN VICTORIA HOSPITAL								0	0
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI		92,904	99,658			19,491	23,810	0	0
106	RADCLIFFE INFIRMARY		27,413	28,328			4,790	6,097	0	0
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS								0	0
108	ROCHDALE	54,381	54,868	57,855		2,067	2,959	12,880	0	56,448
109	ROTHERHAM GENERAL HOSPITALS		52,744	57,621			5,866	6,436	0	0
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS		76,116	79,146			6,454	7,267	0	0
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	60,538	61,239	66,520		1,936	4,015	4,237	0	62,474
112	ROYAL BROMPTON HOSPITAL								0	0
113	ROYAL CORNWALL HOSPITALS	67,272	68,616	73,139		6,615	8,008	8,349	0	73,887
114	ROYAL DEVON AND EXETER		78,480	84,565			10,123	10,407	0	0
115	ROYAL FREE HAMPSTEAD	89,207	92,652	100,415	21,703	21,934	25,581	26,525	100,387	111,141
116	ROYAL HULL HOSPITALS		84,442	93,764			8,770	7,441	0	0
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	79,426	78,850	83,788	13,760	14,625	19,043	19,758	88,665	94,051
118	ROYAL SHREWSBURY HOSPITALS								0	0
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	43,838	48,291	48,599	3,036	4,092	4,536	5,820	47,922	47,930
120	ROYAL UNITED HOSPITAL BATH	51,489	54,668	59,494		5,325	7,024	8,024	0	56,814
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI								0	0
122	ROYAL WEST SUSSEX								0	0
123	ROYAL WOLVERHAMPTON HOSPITALS								0	0
124	SALFORD ROYAL HOSPITALS								0	0
125	SCUNTHORPE & GOOLE HOSPITALS		45,197	45,630			4,716	4,951	0	0
126	SOUTH KENT HOSPITALS								0	0
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS								0	0
128	SOUTH TEES ACUTE HOSPITALS	82,232	89,105	96,221		6,779	7,364	11,355	0	89,011
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS		35,769	36,682			5,319	6,307	0	0
130	SOUTHAMPTON UNIVERSITY HOSPITALS		115,991	130,153			30,866	33,608	0	0
131	SOUTHEND	55,636	57,441	61,863	3,717	3,523	6,642	6,332	54,514	59,159
132	SOUTHPORT AND FORMBY	30,247	31,781	33,145		2,333	2,837	3,735	0	32,580
133	ST ALBANS AND HEMEL HEMPSTEAD								0	0
134	ST GEORGE'S		104,633	103,337			34,476	39,755	0	0
135	ST HELENS AND KNOWSLEY HOSPITALS	74,028	76,903	79,348	7,567	6,119	6,853	8,016	76,498	80,147
136	ST HELIER	78,838	77,065	77,386	6,298	8,020	11,330	9,366	71,355	86,858
137	ST JAMES'S UNIVERSITY HOSPITAL	96,166	100,831	111,979	10,960	13,718	19,615	19,125	93,761	109,884
138	ST MARY'S (IoW)		30,179	31,208			4,654	5,077	0	0
139	ST MARY'S		83,877	88,502			24,110	23,149	0	0
140	STOCKPORT ACUTE SERVICES								0	0
141	STOKE MANDEVILLE HOSPITAL								0	0
142	SWINDON AND MARLBOROUGH								0	0
143	TAMESIDE AND GLOSSOP ACUTE SERVICES								0	0
144	THANET		32,505	33,408			2,031	2,960	0	0
145	UNITED LEEDS TEACHING HOSPITALS	120,050	124,254	130,297	18,783	21,509	26,092	28,504	128,266	141,559
146	UNIVERSITY COLLEGE LONDON HOSPITALS								0	0
147	WALSALL HOSPITALS	53,090	55,637	56,600	846	2,731	2,997	5,318	52,192	55,821
148	WALSGRAVE HOSPITALS		89,125	93,303			9,431	9,613	0	0
149	WARRINGTON HOSPITAL		42,542	44,559			4,007	4,011	0	0
150	WEST DORSET GENERAL HOSPITALS	35,198	36,296	38,137	2,812	2,678	3,829	4,267	36,889	37,876
151	WEST MIDDLESEX UNIVERSITY HOSPITAL		43,309	42,688			7,381	7,469	0	0
152	WEST SUFFOK HOSPITALS		42,498	45,651			3,755	4,104	0	0
153	WESTMORLAND HOSPITALS		14,844	15,952			450	495	0	0
154	WHITTINGTON HOSPITAL		55,618	54,208			13,358	14,109	0	0
155	WINCHESTER & EASTLEIGH								0	0
156	WIRRAL HOSPITAL	82,133	84,859	89,381	4,551	8,912	9,762	9,174	84,598	91,045
157	WORTHING & SOUTHLANDS HOSPITALS								0	0

	A	AL	AM	AN	AO	AP	AQ	AR	AS	AT
1		£k	£k	£k	£k	£k	£k			
2	NAME	TOTAL INCOME	TOTAL INCOME	EXPENDITURE	EXPENDITURE	EXPENDITURE	EXPENDITURE	M&D wte	M&D wte	M&D wte
3		Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94
4		1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94
5										
6	ADDENBROOKE'S	126,772	134,778			118,999	128,791			353
7	AIREDALE	57,396	60,350		53,228	53,976	57,151		133	132
8	ALEXANDRA	0	32,793				31,230			
9	BARNSLEY DISTRICT GENERAL HOSPITAL	48,380	50,134			45,594	47,653			147
10	BASILDON & THURROCK GENERAL HOSPITALS	65,560	68,720		59,408	60,556	63,617		202	216
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	33,148	35,415		29,667	31,174	33,363		78	82
12	BEDFORD HOSPITAL	41,456	43,393		33,256	39,077	41,717		114	136
13	BIRMINGHAM HEARTLANDS HOSPITAL	74,010	87,434		58,651	68,863	80,569		236	236
14	BISHOP AUCKLAND HOSPITALS	0	32,378				31,277			
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	0	0							
16	BOLTON HOSPITALS	0	0							
17	BRADFORD HOSPITALS	93,411	99,283	74,405	85,791	88,297	93,792	290	274	252
18	BRIGHTON	81,804	82,884			79,244	80,371			233
19	BROADGREEN HOSPITAL	41,338	38,517	37,058	42,759	39,430	36,476	104	124	108
20	BROMLEY HOSPITALS	66,048	65,647			61,224	61,650			195
21	BURTON HOSPITALS	47,013	47,558			41,397	44,244			103
22	CARLISLE HOSPITALS	0	0							
23	CENTRAL MIDDLESEX HOSPITAL	48,340	47,255	40,409	43,733	44,364	43,982	139	138	137
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	121,780	127,237		107,093	115,892	121,354		337	397
25	CHASE FARM HOSPITALS	46,012	47,197			42,681	44,238			130
26	CHELSEA & WESTMINSTER	0	0							
27	CHESTERFIELD & NORTH DERBYSHIRE RDYAL HOSPI	55,272	56,295			51,895	53,605			152
28	CITY HOSPITAL	0	0							
29	CITY HOSPITAL SUNDERLAND	0	0							
30	CRAWLEY HORSHAM	43,775	43,650			41,530	43,612			118
31	DARLINGTON MEMORIAL HOSPITAL	0	0							
32	DARTFORD AND GRAVESHAM	0	0							
33	DERBY CITY GENERAL HOSPITAL	41,905	46,712			39,233	45,066			130
34	DERBYSHIRE ROYAL INFIRMARY	0	0							
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	67,064	71,324	55,552	59,788	63,287	67,349	176	189	198
36	DUDLEY GRDUP DF HOSPITALS	0	0							
37	EALING HOSPITAL	42,945	43,834		39,868	40,787	41,803		104	101
38	EAST HERFORDSHIRE	57,994	59,742		53,596	54,993	56,854		173	143
39	EAST YORKSHIRE HOSPITALS	40,226	41,512			37,192	40,013			124
40	EASTBOURNE HDSPITALS	61,521	64,038		53,952	57,527	60,410		120	130
41	EPSOM	47,503	48,381	40,415	44,470	44,352	46,268	133	136	138
42	FREEMAN GROUP OF HOSPITALS	77,678	92,544	63,876	71,418	74,480	89,315	144	188	186
43	FRIMLEY PARK HOSPITAL	44,909	49,656		385,689	42,347	47,135		143	143
44	FURNESS HOSPITALS	0	0							
45	GATESHEAD HOSPITALS	41,594	44,500			39,222	42,219			133
46	GEORGE ELIOT HOSPITAL	0	0							
47	GLENFIELD HOSPITAL	48,599	50,849			44,623	47,584			121
48	GLOUCESTERSHIRE ROYAL	64,249	67,910			61,096	64,654			158
49	GOOD HOPE HOSPITAL	43,280	47,492			40,571	45,058			122
50	GUY'S AND ST THOMAS' HOSPITAL	271,038	256,324			255,058	241,671			726
51	HALTON GENERAI HOSPITAL	21,065	21,708			19,951	20,614			53
52	HAMMERSMITH HOSPITALS	0	0							
53	HARTLEPOOL AND PETERLEE HOSPITALS	0	0							
54	HAVERING HOSPITALS	94,139	94,053			82,290	88,737			270
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS									
56	HEREFORD HOSPITALS	0	0							
57	HILLINGDON HOSPITAL	51,314	52,510	42,620	47,165	47,647	49,628	131	148	147
58	HINCHINGBROKE	36,852	39,013			35,126	38,168			94
59	HORTON GENERAL HOSPITAL	19,391	19,560			17,765	18,575			61
60	IPSWICH HOSPITAL	65,425	70,224			61,824	66,960			203
61	JAMES PAGET HOSPITAL	40,795	54,212			38,463	52,368			152
62	KENT & CANTERBURY HOSPITALS	49,718	54,205			47,792	51,877			154
63	KENT AND SUSSEX WEALD	0	0							
64	KETTERING GENERAL HOSPITAL	0	0							
65	KING'S	142,498	138,536			138,620	133,995			490
66	KING'S LYNN & WISBECH HOSPITALS	51,535	53,640		47,099	48,789	51,303		166	158
67	KINGSOTN HOSPITAL	42,555	45,612	37,446	41,289	40,706	42,724	125	133	133
68	LANCASTER ACUTE HOSPITALS	41,920	42,740		39,816	39,521	40,214		125	127
69	LEICESTER GENERAL HOSPITAL	59,966	63,380			55,953	59,849			155
70	LEICESTER ROYAL INFIRMARY	107,730	117,975			101,115	111,507			401
71	LEWISHAM HOSPITAL	63,954	64,354			59,855	60,322			148
72	LINCOLN HOSPITALS	0	0							
73	LOUTH AND DISTRICT	0	0							
74	LUTON AND DUNSTABLE HOSPITAL	51,976	55,440		48,508	49,336	52,287		154	159
75	MAYDAY	64,275	65,796			61,232	62,837			191
76	MEDWAY	0	0							
77	MID CHESHIRE HOSPITALS	52,562	54,897	41,657	46,999	51,024	52,008	138	135	141
78	MID ESSEX HOSPITALS	62,285	65,749		570,195	58,313	61,782		178	172
79	MID KENT	55,407	58,385			51,680	55,341			134
80	MID STAFFORDSHIRE GENERAL HOSPITALS	56,855	56,112			50,360	53,268			136
81	MILTON KEYNES GENERAL	38,576	41,200		33,906	36,121	38,232		119	124

	A	AL	AM	AN	AO	AP	AQ	AR	AS	AT
1		£k	£k	£k	£k	£k	£k			
2	NAME	TOTAL INCOME	TOTAL INCOME	EXPENDITURE	EXPENDITURE	EXPENDITURE	EXPENDITURE	M&D wte	M&D wte	M&D wte
3		Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94
4		1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94
5										
82	MOUNT VERNON & WATFORD HOSPITALS	0	0							
83	NEWHAM	0	0							
84	NORFOLK & NORWICH	0	0							
85	NORTH DURHAM ACUTE HOSPITALS	0	0							
86	NORTH HAMPSHIRE HOSPITALS	0	0							
87	NORTH MIDDLESEX HOSPITAL	51,221	54,464	44,080	47,035	47,964	51,108	193	169	149
88	NORTH STAFFORDSHIRE HOSPITAL	125,460	126,744			116,531	122,661			352
89	NORTHAMPTON GENERAL HOSPITAL	0	0							
90	NORTHERN GENERAL HOSPITAL	110,009	117,138	81,188	96,274	102,723	109,972	190	205	276
91	NORTHWICK PARK & ST MARK'S	67,086	79,620			62,935	75,094			206
92	NOTTINGHAM CITY HOSPITAL	106,683	113,214		86,911	99,900	105,618		231	237
93	OXFORD RADCLIFFE HOSPITAL	0	0							
94	PETERBOROUGH HOSPITALS	60,785	62,424			55,741	60,716			182
95	PILGRIM HEALTH	0	0							
96	PINDERFIELDS HOSPITALS	59,961	63,359			57,388	61,672			153
97	PLYMOUTH HOSPITALS	0	0							
98	PONTEFRACT HOSPITALS	39,165	39,736			37,287	38,254			95
99	POOLE HOSPITAL	55,317	60,826		48,204	52,805	58,231		178	173
100	PORTSMOUTH HOSPITALS	0	0							
101	PRESTON ACUTE HOSPITALS	0	0							
102	PRINCESS ROYAL HOSPITAL	26,838	28,230			24,481	26,863			79
103	QUEEN MARY'S SIDCUP	43,000	43,831			40,610	42,029			124
104	QUEEN VICTORIA HOSPITAL	0	0							
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	112,395	123,468			104,670	117,497			380
106	RADCLIFFE INFIRMARY	32,203	34,425			29,684	32,276			90
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	0	0							
108	ROCHDALE	57,827	70,735		52,978	54,649	67,685		137	140
109	ROTHERHAM GENERAL HOSPITALS	58,610	64,057			55,659	59,611			
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	82,570	86,413			76,945	81,479			244
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	65,254	70,757		57,759	60,867	66,542		154	172
112	ROYAL BROMPTON HOSPITAL	0	0							
113	ROYAL CORNWALL HOSPITALS	76,624	81,488		70,565	72,755	77,535		236	251
114	ROYAL DEVON AND EXETER	88,603	94,972			81,772	90,382			248
115	ROYAL FREE HAMPSTEAD	118,233	126,940	93,862	104,946	111,485	119,928	271	266	294
116	ROYAL HULL HOSPITALS	93,212	101,205			90,459	98,578			233
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	97,893	103,546	84,395	91,951	94,502	97,629	223	299	261
118	ROYAL SHREWSBURY HOSPITALS	0	0							
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	52,827	54,419	41,679	47,125	49,713	51,800	159	166	172
120	ROYAL UNITED HOSPITAL BATH	61,692	67,518		53,959	58,144	66,049		254	240
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	0	0							
122	ROYAL WEST SUSSEX	0	0							
123	ROYAL WOLVERHAMPTON HOSPITALS	0	0							
124	SALFORD ROYAL HOSPITALS	0	0							
125	SCUNTHORPE & GOOLE HOSPITALS	49,913	50,581			46,336	46,667			118
126	SOUTH KENT HOSPITALS	0	0							
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	0	0							
128	SOUTH TEES ACUTE HOSPITALS	96,469	107,576		84,503	91,988	103,654		237	250
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	41,088	42,989			41,018	41,386			121
130	SOUTHAMPTON UNIVERSITY HOSPITALS	146,857	163,761			139,007	155,435			443
131	SOUTHEND	64,083	68,195	51,329	56,415	60,434	64,647	198	205	199
132	SOUTHPORT AND FORMBY	34,618	36,881		30,473	31,869	34,173		159	90
133	ST ALBANS AND HEMEL HEMPSTEAD	0	0							
134	ST GEORGE'S	139,109	143,092			130,355	135,942			504
135	ST HELENS AND KNOWSLEY HOSPITALS	83,756	87,362	71,250	75,216	77,488	81,476	208	212	193
136	ST HELIER	88,395	86,752	67,467	82,201	84,161	81,448	209	239	260
137	ST JAMES'S UNIVERSITY HOSPITAL	120,446	131,104	90,632	107,096	116,013	126,476	323	360	367
138	ST MARY'S (IOW)	34,833	36,285			31,781	33,983			105
139	ST MARY'S	107,987	111,651			103,181	107,207			321
140	STOCKPORT ACUTE SERVICES	0	0							
141	STOKE MANDEVILLE HOSPITAL	0	0							
142	SWINDON AND MARLBOROUGH	0	0							
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	0	0							
144	THANET	34,536	36,368			32,722	35,132			88
145	UNITED LEEDS TEACHING HOSPITALS	150,346	156,801	120,377	135,659	144,032	152,106	429	460	324
146	UNIVERSITY COLLEGE LONDON HOSPITALS	0	0							
147	WALSALL HOSPITALS	58,634	61,918	46,425	54,338	53,450	57,344	123	128	132
148	WALSGRAVE HOSPITALS	98,556	102,916			95,453	99,699			
149	WARRINGTON HOSPITAL	46,549	48,570			44,621	46,119		129	134
150	WEST DORSET GENERAL HOSPITALS	40,125	42,404	132	117	122	127	1,343	1,326	1,324
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	50,690	50,157			47,192	47,310			156
152	WEST SUFFOK HOSPITALS	46,253	49,755			44,148	47,682			119
153	WESTMORLAND HOSPITALS	15,294	16,447			13,826	14,624			37
154	WHITTINGTON HOSPITAL	68,976	68,317			64,739	65,438			233
155	WINCHESTER & EASTLEIGH	0	0							
156	WIRRAL HOSPITAL	94,621	98,555	79,816	85,606	87,642	92,097	225	209	242
157	WORTHING & SOUTHLANDS HOSPITALS	0	0							

	A	AU	AV	AW	AX	AY	AZ	BA	BB	BC	BD
1		STAFFING					PATIENT ACTIVITY - in accounts				
2	NAME	M&D wte	TOTAL STAFF wte	TOTAL STAFF wte	TOTAL STAFF wte	TOTAL STAFF wte	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	DAY CASES FCE
3		Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92
4		1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92
5											
6	ADDENBROOKE'S	379			4,195	4,053					
7	AIREDALE	145		2,232	2,232	2,246	27,497	27,215	27,074	27,724	6,426
8	ALEXANDRA	96				1,162			17,627	19,692	
9	BARNSLEY DISTRICT GENERAL HOSPITAL	143			1,659	1,658		31,464	31,209	32,234	
10	BASILDON & THURROCK GENERAL HOSPITALS	217		2,058	2,122	2,168	34,832	35,893	36,876	38,051	5,974
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	83		1,238	1,250	1,264			17,952	18,278	
12	BEDFORD HOSPITAL	140		1,210	1,392	1,457					
13	BIRMINGHAM HEARTLANDS HOSPITAL	235		1,841	2,023	2,490			41,443		
14	BISHOP AUCKLAND HOSPITALS	76				1,133					
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY										
16	BOLTON HOSPITALS										
17	BRADFORD HOSPITALS	222	2,919	2,916	2,860	2,874					
18	BRIGHTON	264			2,973	2,901			56,000	51,473	
19	BROADGREEN HOSPITAL	102	1,574	1,599	1,301	1,155	18,845	19,133		15,921	4,770
20	BROMLEY HOSPITALS	181			2,158	2,072			39,600	47,851	
21	BURTON HOSPITALS	108			1,501	1,561					
22	CARLISLE HOSPITALS										
23	CENTRAL MIDDLESEX HOSPITAL	144	1,330	1,308	1,271	1,265					
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	453		5,488	5,501	5,421		60,744	64,322	64,487	
25	CHASE FARM HOSPITALS	139			1,241	1,240			22,554	22,583	
26	CHELSEA & WESTMINSTER										
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	186			1,969	2,040					
28	CITY HOSPITAL										
29	CITY HOSPITAL SUNDERLAND										
30	CRAWLEY HORSHAM	124			1,456	1,413		24,276	24,826	23,036	
31	DARLINGTON MEMORIAL HOSPITAL										
32	DARTFORD AND GRAVESHAM										
33	DERBY CITY GENERAL HOSPITAL	138			1,468	1,679			28,663	31,763	
34	DERBYSHIRE ROYAL INFIRMARY										
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	209	2,468	2,554	2,692	2,788			58,097	62,167	
36	DUDLEY GROUP OF HOSPITALS										
37	EALING HOSPITAL	118		968	1,025	1,041		23,786		24,821	
38	EAST HERFORDSHIRE	156		2,279	1,860	1,887				35,000	
39	EAST YORKSHIRE HOSPITALS	136			1,577	1,554					
40	EASTBOURNE HOSPITALS	135		2,255	2,320	2,476		35,187		35,500	
41	EPSOM	143	1,680	1,678	1,544	1,572					
42	FREEMAN GROUP OF HOSPITALS	207	2,263	2,304	2,355	2,500	35,809	36,577	36,299		13,245
43	FRIMLEY PARK HOSPITAL	159		1,418	1,477	1,521		29,232	31,910	32,433	
44	FURNESS HOSPITALS										
45	GATESHEAD HOSPITALS	134			1,569	1,619			25,565	25,958	
46	GEORGE ELIOT HOSPITAL										
47	GLENFIELD HOSPITAL	125			1,458	1,393					
48	GLOUCESTERSHIRE ROYAL	164			2,225	2,265			38,300		
49	GOOD HOPE HOSPITAL	125			1,508	1,458				33,238	
50	GUY'S AND ST THOMAS' HOSPITAL	652			6,838	6,393		78,944	78,954	90,025	
51	HALTON GENERAL HOSPITAL	55			708	710		8,051	8,239	8,874	
52	HAMMERSMITH HOSPITALS										
53	HARTLEPOOL AND PETERLEE HOSPITALS										
54	HAVERING HOSPITALS	295			2,754	2,679		64,605	67,773	67,256	
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS										
56	HEREFORD HOSPITALS										
57	HILLINGDON HOSPITAL	159	1,655	1,693	1,644	1,630					
58	HINCHINGBROKE	96			1,221	1,278			17,639	18,159	
59	HORTON GENERAL HOSPITAL	65			650	667					
60	IPSWICH HOSPITAL	213			2,480	2,534					
61	JAMES PAGET HOSPITAL	155			1,846	1,914			23,444	28,778	
62	KENT & CANTERBURY HOSPITALS	166			1,528	1,568			25,000		
63	KENT AND SUSSEX WEALD										
64	KETTERING GENERAL HOSPITAL										
65	KING'S	440			5,123	4,524				52,196	
66	KING'S LYNN & WISBECH HOSPITALS	162		2,005	1,993	1,973			25,890		
67	KINGSOTN HOSPITAL	138	1,232	1,243	1,188	1,155	23,597	24,628	21,448	19,615	7,691
68	LANCASTER ACUTE HOSPITALS	129		1,595	1,526	1,517	23,887	22,660	23,176	24,000	8,812
69	LEICESTER GENERAL HOSPITAL	180			1,971	1,977		36,481	38,928	43,580	
70	LEICESTER ROYAL INFIRMARY	377			3,602	3,906			59,258	67,899	
71	LEWISHAM HOSPITAL	166			1,851	1,906			35,047	33,723	
72	LINCOLN HOSPITALS										
73	LOUTH AND DISTRICT										
74	LUTON AND DUNSTABLE HOSPITAL	180		1,775	1,794	1,803					
75	MAYDAY	196			1,918	1,896			33,929	33,310	
76	MEDWAY										
77	MID CHESHIRE HOSPITALS	145	1,766	1,885	1,954	1,899	34,563	33,932	32,198	32,960	5,488
78	MID ESSEX HOSPITALS	171		2,301	2,237	2,213					
79	MID KENT	140			1,836	1,839					
80	MID STAFFORDSHIRE GENERAL HOSPITALS	139			2,038	1,971					
81	MILTON KEYNES GENERAL	129		1,286	1,305	1,344	24,000	25,477	25,912	28,255	

	A	AU	AV	AW	AX	AY	AZ	BA	BB	BC	BD
1		STAFFING					PATIENT ACTIVITY - in accounts				
2	NAME	M&D wte	TOTAL STAFF wte	TOTAL STAFF wte	TOTAL STAFF wte	TOTAL STAFF wte	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	DAY CASES FCE
3		Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92
4		1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92
82	MOUNT VERNON & WATFORD HOSPITALS										
83	NEWHAM										
84	NORFOLK & NORWICH										
85	NORTH DURHAM ACUTE HOSPITALS										
86	NORTH HAMPSHIRE HOSPITALS										
87	NORTH MIDDLESEX HOSPITAL	157	1,666	1,587	1,406	1,415					
88	NORTH STAFFORDSHIRE HOSPITAL	390			4,451	4,602					
89	NORTHAMPTON GENERAL HOSPITAL										
90	NORTHERN GENERAL HOSPITAL	329	3,237	3,446	3,592	3,641					
91	NORTHWICK PARK & ST MARK'S	224			1,879	2,120					
92	NOTTINGHAM CITY HOSPITAL	254		3,506	3,643	3,748			49,927	52,889	
93	OXFORD RADCLIFFE HOSPITAL										
94	PETERBOROUGH HOSPITALS	186			2,139	2,090		44,021	46,173	48,326	
95	PILGRIM HEALTH										
96	PINDERFIELDS HOSPITALS	161			2,149	2,165					
97	PLYMOUTH HOSPITALS										
98	PONTEFRACT HOSPITALS	109			1,245	1,213					
99	POOLE HOSPITAL	201		1,865	1,967	2,070	37,491	39,980	44,073	49,000	
100	PORTSMOUTH HOSPITALS										
101	PRESTON ACUTE HOSPITALS										
102	PRINCESS ROYAL HOSPITAL	81			940	950					
103	QUEEN MARY'S SIDCUP	130			1,310	1,304					
104	QUEEN VICTORIA HOSPITAL										
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	420			3,869	4,186					
106	RADCLIFFE INFIRMARY	94			1,009	1,018					
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS										
108	ROCHDALE	145		2,517	2,306	2,449	25,180	24,775	24,188	24,953	7,398
109	ROTHERHAM GENERAL HOSPITALS										
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	247			2,779	2,832					
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	189		2,191	2,261	2,393			50,000	56,000	
112	ROYAL BROMPTON HOSPITAL										
113	ROYAL CORNWALL HOSPITALS	244		2,454	2,486	2,563			60,183	58,903	
114	ROYAL DEVON AND EXETER	255			2,819	2,865			47,193	52,417	
115	ROYAL FREE HAMPSTEAD	325	3,327	3,426	3,444	3,337	37,703	47,612	53,731	58,501	
116	ROYAL HULL HOSPITALS	242			3,198	3,255					
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	286	2,923	3,049	2,918	2,888		50,580	54,020	58,097	
118	ROYAL SHREWSBURY HOSPITALS										
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	177	1,504	1,593	1,555	1,531					
120	ROYAL UNITED HOSPITAL BATH	295		2,555	2,103	2,249					
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI										
122	ROYAL WEST SUSSEX										
123	ROYAL WOLVERHAMPTON HOSPITALS										
124	SALFORD ROYAL HOSPITALS										
125	SCUNTHORPE & GOOLE HOSPITALS	124			1,576	1,592					
126	SOUTH KENT HOSPITALS										
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS										
128	SOUTH TEES ACUTE HOSPITALS	264		2,911	3,077	3,327	69,362	72,000	76,000	84,100	
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	124			1,694	1,598					
130	SOUTHAMPTON UNIVERSITY HOSPITALS	485			4,452	4,726					
131	SOUTHEND	209	2,395	2,313	2,199	2,178					
132	SOUTHPORT AND FORMBY	97		1,886	1,279	1,298					
133	ST ALBANS AND HEMEL HEMPSTEAD										
134	ST GEORGE'S	508			3,599	3,585		62,727	64,694	67,650	
135	ST HELENS AND KNOWSLEY HOSPITALS	207	3,225	3,126	3,030	3,054					
136	ST HELIER	254	2,103	2,488	2,389	2,372					
137	ST JAMES'S UNIVERSITY HOSPITAL	423	3,796	4,037	4,180	4,290	33,580	39,091	42,878	47,008	
138	ST MARY'S (IoW)	118			1,075	1,139			22,162	22,538	
139	ST MARY'S	341			2,414	2,381		36,900	31,500	37,635	
140	STOCKPORT ACUTE SERVICES										
141	STOKE MANDEVILLE HOSPITAL										
142	SWINDON AND MARLBORDUGH										
143	TAMESIDE AND GLOSSOP ACUTE SERVICES										
144	THANET	91			1,097	1,085			19,243	19,445	
145	UNITED LEEDS TEACHING HOSPITALS	340	5,763	6,389	5,095	5,227					
146	UNIVERSITY COLLEGE LONDON HOSPITALS										
147	WALSALL HOSPITALS	135	1,935	1,977	2,004	2,085			35,281	35,200	
148	WALSGRAVE HOSPITALS										
149	WARRINGTON HOSPITAL	146		1,911	1,724	1,745					
150	WEST DORSET GENERAL HOSPITALS	1,350									
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	156			1,459	1,284					
152	WEST SUFFOK HOSPITALS	140			1,608	1,652		30,987	30,433	36,132	
153	WESTMORLAND HOSPITALS	32			523	504		6,878	7,315	7,517	
154	WHITTINGTON HOSPITAL	215			2,217	2,225					
155	WINCHESTER & EASTLEIGH										
156	WIRRAL HOSPITAL	256	3,300	3,350	3,421	3,611		54,151	59,992	61,368	
157	WORTHING & SOUTHLANDS HOSPITALS										

	A	BE	BF	BG	BH	BI	BJ	BK	BL	BM	BN
1					PATIENT ACTIVITY - in other source Do						
2	NAME	DAY CASES FCE	DAY CASES FCE	DAY CASES FCE	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	DAY CASES FCE	DAY CASES FCE	DAY CASES FCE
3		Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94
4		1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94
5											
6	ADDENBROOKE'S						52,081	54,537			11,679
7	AIREDALE	7,756	8,527	10,253		27,391	27,074	27,723		7,754	8,527
8	ALEXANDRA		5,338	6,549			19,774	21,615			5,376
9	BARNSLEY DISTRICT GENERAL HOSPITAL	6,011	7,425	8,525			34,156	34,814			7,625
10	BASILDON & THURROCK GENERAL HOSPITALS	7,137	8,859	11,785		35,832	36,879	38,744		7,025	8,840
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES					15,774	16,568	16,344		2,577	2,751
12	BEDFORD HOSPITAL					25,976	27,726	23,415		6,142	7,382
13	BIRMINGHAM HEARTLANDS HOSPITAL		7,594				45,532	48,235			7,770
14	BISHOP AUCKLAND HOSPITALS						20,519	20,785			5,384
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY						43,477	45,350			11,373
16	BOLTON HOSPITALS						42,990	42,389			9,135
17	BRADFORD HOSPITALS				69,181	69,068	68,815	68,287	12,095	14,150	16,298
18	BRIGHTON						43,601	43,639			10,983
19	BROADGREEN HOSPITAL	4,823		5,157	18,845	19,133	17,484	15,921	4,770	4,823	5,559
20	BROMLEY HOSPITALS						32,731	31,612			10,426
21	BURTON HOSPITALS						26,291	28,167			6,487
22	CARLISLE HOSPITALS						28,108	26,630			6,253
23	CENTRAL MIDDLESEX HOSPITAL				22,764	23,287	20,244	21,748	5,234	5,545	5,911
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS					49,319	54,652	53,915		11,138	13,255
25	CHASE FARM HOSPITALS		9,705	10,616			26,120	28,502			9,790
26	CHELSEA & WESTMINSTER							28,859			
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI						37,362	37,513			10,271
28	CITY HOSPITAL						40,970	47,347			13,588
29	CITY HOSPITAL SUNDERLAND						55,757	51,978			14,622
30	CRAWLEY HORSHAM						19,293	20,307			3,936
31	DARLINGTON MEMORIAL HOSPITAL						20,089	19,967			6,291
32	DARTFORD AND GRAVESHAM						28,588	28,221			6,699
33	DERBY CITY GENERAL HOSPITAL		5,206	8,923			33,603	36,543			5,204
34	DERBYSHIRE ROYAL INFIRMARY						27,696	26,717			9,360
35	DONCASTER ROYAL & MANOTAGU HOSPITAL				46,042	47,204	49,795	51,327	5,576	8,903	11,745
36	DUDLEY GROUP OF HOSPITALS						51,033	51,768			17,762
37	EALING HOSPITAL					20,585	21,316	21,654		5,560	6,311
38	EAST HERFORDSHIRE					24,005	24,930	25,617		6,152	7,338
39	EAST YORKSHIRE HOSPITALS						21,508	20,898			5,586
40	EASTBOURNE HOSPITALS					28,887	31,434	31,707		5,040	6,554
41	EPSOM				20,986	21,687	21,485	20,851	4,643	5,396	5,774
42	FREEMAN GROUP OF HOSPITALS	13,075	14,079		35,777	36,340	36,299	38,778	13,280	13,473	14,078
43	FRIMLEY PARK HOSPITAL					26,829	28,187	28,948		6,657	9,308
44	FURNESS HOSPITALS						19,072	18,666			4,544
45	GATESHEAD HOSPITALS		3,200	3,515			25,383	25,958			3,200
46	GEORGE ELIOT HOSPITAL						28,890	30,156			8,648
47	GLENFIELD HOSPITAL						15,608	16,583			4,731
48	GLOUCESTERSHIRE ROYAL		9,600				41,799	41,062			9,815
49	GOOD HOPE HOSPITAL			8,304			31,915	33,238			6,195
50	GUY'S AND ST THOMAS' HOSPITAL						70,697	71,024			24,835
51	HALTON GENERAL HOSPITAL	6,575	7,352	7,495			8,282	8,924			7,417
52	HAMMERSMITH HOSPITALS							50,866			
53	HARTLEPOOL AND PETERLEE HOSPITALS							22,630			
54	HAVERING HOSPITALS	10,778	15,712	18,479			51,025	48,777			12,898
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS					44,106	43,093	43,377		8,061	11,858
56	HEREFORD HOSPITALS						22,946	23,585			6,868
57	HILLINGDON HOSPITAL				25,444	24,341	25,949	25,829	4,555	4,947	6,416
58	HINCHINGBROKE		8,584	9,310		18,040	17,639	18,159		6,757	8,584
59	HORTON GENERAL HOSPITAL						11,537	11,823			2,940
60	IPSWICH HOSPITAL						44,800	45,882			10,063
61	JAMES PAGET HOSPITAL		14,696	18,279			26,222	28,778			9,592
62	KENT & CANTERBURY HOSPITALS		10,000				28,157	28,491			10,218
63	KENT AND SUSSEX WEALD							26,340			
64	KETTERING GENERAL HOSPITAL						34,335	35,040			9,038
65	KING'S						38,701	40,192			13,536
66	KING'S LYNN & WISBECH HOSPITALS		7,727			27,743	28,438	29,161		6,261	7,709
67	KINGSOTN HOSPITAL	9,562	10,892	12,943	26,080	29,274	23,813	24,826	7,690	9,562	10,893
68	LANCASTER ACUTE HOSPITALS	10,394	10,569	12,000		25,234	25,089	25,133		10,768	10,569
69	LEICESTER GENERAL HOSPITAL	9,410	11,548	12,399			36,416	37,627			13,992
70	LEICESTER ROYAL INFIRMARY		20,683	23,690			63,749	72,794			20,662
71	LEWISHAM HOSPITAL						28,355	28,050			6,626
72	LINCOLN HOSPITALS							32,086			
73	LOUTH AND DISTRICT						5,536	5,382			1,670
74	LUTON AND DUNSTABLE HOSPITAL					36,101	37,669	37,286		7,150	7,928
75	MAYDAY		11,388	13,536			37,891	36,483			11,316
76	MEDWAY						32,826	33,669			6,662
77	MID CHESHIRE HOSPITALS	6,715	9,226	12,560	34,913	33,932	34,834	35,352	5,365	6,715	9,270
78	MID ESSEX HOSPITALS					36,576	37,978	38,872		6,296	8,293
79	MID KENT						27,964	28,794			9,441
80	MID STAFFORDSHIRE GENERAL HOSPITALS						31,641	31,337			8,027
81	MILTON KEYNES GENERAL					25,029	27,140	25,740		3,734	4,215

	A	BE	BF	BG	BH	BI	BJ	BK	BL	BM	BN
1									PATIENT ACTIVITY - In other source Do		
2	NAME	DAY CASES FCE	DAY CASES FCE	DAY CASES FCE	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	INPATIENTS FCE	DAY CASES FCE	DAY CASES FCE	DAY CASES FCE
3		Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94
4		1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94
5											
82	MOUNT VERNON & WATFORD HOSPITALS				14,833	13,676	14,989	37,378	4,583	8,949	9,647
83	NEWHAM						33,052	30,016			10,158
84	NORFOLK & NORWICH						67,377	74,475			18,529
85	NORTH DURHAM ACUTE HOSPITALS						36,368	38,923			7,582
86	NORTH HAMPSHIRE HOSPITALS							21,130			
87	NORTH MIDDLESEX HOSPITAL				25,630	24,753	24,429	24,116	9,410	8,867	10,690
88	NORTH STAFFORDSHIRE HOSPITAL						78,858	78,512			13,833
89	NORTHAMPTON GENERAL HOSPITAL						40,245	42,251			12,897
90	NORTHERN GENERAL HOSPITAL				47,293	47,015	47,714	48,952	3,579	5,133	8,312
91	NORTHWICK PARK & ST MARK'S						29,253	30,136			9,507
92	NOTTINGHAM CITY HOSPITAL		9,441	13,032		52,507	54,696	57,091		8,483	10,198
93	OXFORD RADCLIFFE HOSPITAL						52,097	65,349			6,439
94	PETERBOROUGH HOSPITALS						42,042	42,187			8,400
95	PILGRIM HEALTH						29,912	29,310			7,555
96	PINDERFIELDS HOSPITALS						30,589	30,843			9,610
97	PLYMOUTH HOSPITALS						65,817	65,007			13,138
98	PONTEFRACT HOSPITALS						27,474	27,276			6,655
99	POOLE HOSPITAL					40,359	39,863	40,595		3,758	7,799
100	PORTSMOUTH HOSPITALS							74,866			
101	PRESTON ACUTE HOSPITALS						53,003	52,461			18,571
102	PRINCESS ROYAL HOSPITAL						15,207	16,176			4,361
103	QUEEN MARY'S SIDCUP						25,764	26,192			4,997
104	QUEEN VICTORIA HOSPITAL						5,911	6,717			2,987
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI						68,175	74,989			12,484
106	RADCLIFFE INFIRMARY						10,849	11,517			1,676
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS						5,196	5,707			693
108	ROCHDALE	9,178	9,816	11,083		26,678	25,961	26,738		9,178	9,819
109	ROTHERHAM GENERAL HOSPITALS						38,122	37,735			8,887
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS						49,517	50,104			13,814
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI					30,973	36,708	37,018		13,386	16,433
112	ROYAL BROMPTON HOSPITAL							10,179			
113	ROYAL CORNWALL HOSPITALS					47,446	52,319	50,258		8,738	11,023
114	ROYAL DEVON AND EXETER		12,009	14,705			51,106	52,417			11,981
115	ROYAL FREE HAMPSTEAD				34,378	33,702	35,330	36,653	5,485	6,959	8,621
116	ROYAL HULL HOSPITALS						59,788	63,251			12,179
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL				38,624	39,165	40,396	42,322	9,354	11,965	14,289
118	ROYAL SHREWSBURY HOSPITALS						38,010	43,266			8,476
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS				27,238	27,298	28,639	29,528	8,037	7,849	7,514
120	ROYAL UNITED HOSPITAL BATH					32,771	34,982	36,890		8,820	11,324
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI						36,698	71,617			13,891
122	ROYAL WEST SUSSEX						21,908	21,994			4,901
123	ROYAL WOLVERHAMPTON HOSPITALS						47,721	59,097			10,208
124	SALFORD ROYAL HOSPITALS						37,707	35,518			11,441
125	SCUNTHORPE & GOOLE HOSPITALS						28,848	28,683			6,083
126	SOUTH KENT HOSPITALS						33,103	33,350			8,445
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS							61,118			
128	SOUTH TEES ACUTE HOSPITALS						66,869	67,352			19,005
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS						24,318	23,882			6,398
130	SOUTHAMPTON UNIVERSITY HOSPITALS						76,260	82,404			26,061
131	SOUTHEND				41,794	40,425	41,102	40,893	8,201	10,588	11,109
132	SOUTHPORT AND FORMBY					17,542	18,271	18,129		7,670	9,008
133	ST ALBANS AND HEMEL HEMPSTEAD						24,632	24,709			7,168
134	ST GEORGE'S						48,279	46,079			17,374
135	ST HELENS AND KNOWSLEY HOSPITALS				40,389	41,885	42,107	45,510	11,100	12,297	12,781
136	ST HELIER				35,556	44,024	43,919	41,053	9,423	10,693	12,469
137	ST JAMES'S UNIVERSITY HOSPITAL				55,394	56,381	57,224	58,034	15,841	21,423	27,313
138	ST MARY'S (IoW)						18,645	18,135			5,462
139	ST MARY'S	16,400	19,000	19,388			35,168	33,366			21,865
140	STOCKPORT ACUTE SERVICES						30,439	30,434			14,567
141	STOKE MANDEVILLE HOSPITAL						26,861	27,848			8,658
142	SWINDON AND MARLBOROUGH						36,522	37,015			7,356
143	TAMESIDE AND GLOSSOP ACUTE SERVICES						26,030	26,450			8,721
144	THANET		5,506	7,531			19,654	19,445			5,805
145	UNITED LEEDS TEACHING HOSPITALS				57,945	59,229	66,039	67,659	16,626	15,506	17,034
146	UNIVERSITY COLLEGE LONDON HOSPITALS							36,331			
147	WALSALL HOSPITALS		9,659	7,900	38,283	40,345	39,278	37,886			9,393
148	WALSGRAVE HOSPITALS						60,508	61,849			13,760
149	WARRINGTON HOSPITAL						37,331	38,534			7,415
150	WEST DORSET GENERAL HOSPITALS				22,111	21,614	22,570	22,207	4,211	4,977	6,313
151	WEST MIDDLESEX UNIVERSITY HOSPITAL						20,696	20,450			9,239
152	WEST SUFFOK HOSPITALS	108,457	128,198	130,194			24,319	25,243			5,663
153	WESTMORLAND HOSPITALS	2,067	2,807	3,148			8,054	8,277			2,865
154	WHITTINGTON HOSPITAL						29,038	29,841			8,041
155	WINCHESTER & EASTLEIGH						25,521	27,789			5,629
156	WIRRAL HOSPITAL	14,847	15,832	21,360	59,584	58,047	63,847	65,044	11,894	14,823	15,941
157	WORTHING & SOUTHLANDS HOSPITALS						34,988	35,933			8,348

	A	BO	BP	BQ	BR	BS	BT	BU	BV	BW	BX
1							Total Episodes - In accounts				To
2	NAME	DAY CASES FCE	Obstetrics FCE	Obstetrics FCE	Obstetrics FCE	Obstetrics FCE	EPISODES FCE	EPISODES FCE	EPISODES FCE	EPISODES FCE	EPISODES FCE
3		Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92
4		1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92
5											
6	ADDENBROOKE'S	17,025			7,840	8,335	0	0	0	0	0
7	AIREDALE	10,254		2,868	3,151	3,651	33,923	34,971	35,601	37,977	0
8	ALEXANDRA	6,554			2,825	3,476	0	0	22,965	26,241	0
9	BARNSLEY DISTRICT GENERAL HOSPITAL	8,513			3,671	3,628	0	37,475	38,634	40,759	0
10	BASILDON & THURROCK GENERAL HOSPITALS	11,129		5,341	9,970	9,922	40,806	43,030	45,735	49,836	0
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	3,243		1,928	2,023	2,053	0	0	17,952	16,278	0
12	BEDFORD HOSPITAL	12,429		3,016	2,942	2,775	0	0	0	0	0
13	BIRMINGHAM HEARTLANDS HOSPITAL	10,175			6,678	10,885	0	0	49,037	0	0
14	BISHOP AUCKLAND HOSPITALS	6,007			3,015	4,981	0	0	0	0	0
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	16,741			5,511	5,528	0	0	0	0	0
16	BOLTON HOSPITALS	11,320			6,787	7,106	0	0	0	0	0
17	BRADFORD HOSPITALS	21,600	8,629	9,178	9,575	9,694	0	0	0	0	81,276
18	BRIGHTON	12,892			6,036	6,018	0	0	56,000	51,473	0
19	BROADGREEN HOSPITAL	5,157					23,615	23,956	0	21,078	23,615
20	BROMLEY HOSPITALS	12,901			5,077	5,015	0	0	39,600	47,851	0
21	BURTON HOSPITALS	7,420			4,020	4,395	0	0	0	0	0
22	CARLISLE HOSPITALS	7,982			2,874	2,695	0	0	0	0	0
23	CENTRAL MIDDLESEX HOSPITAL	7,915	3,444	3,751	3,197	4,068	0	0	0	0	27,998
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	14,798		6,192	6,323	6,149	0	60,744	64,322	64,487	0
25	CHASE FARM HOSPITALS	10,622			4,784	6,519	0	0	32,259	33,199	0
26	CHELSEA & WESTMINSTER	8,009				3,315	0	0	0	0	0
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	11,597			5,205	5,031	0	0	0	0	0
28	CITY HOSPITAL	19,900			5,382	5,324	0	0	0	0	0
29	CITY HOSPITAL SUNDERLAND	17,689			6,263	7,115	0	0	0	0	0
30	CRAWLEY HORSHAM	4,445			2,464	2,735	0	24,276	24,826	23,036	0
31	DARLINGTON MEMORIAL HOSPITAL	7,323			1,906	1,971	0	0	0	0	0
32	DARTFORD AND GRAVESHAM	7,158			4,360	3,766	0	0	0	0	0
33	DERBY CITY GENERAL HOSPITAL	8,923			7,520	7,387	0	0	33,869	40,686	0
34	DERBYSHIRE ROYAL INFIRMARY	10,748					0	0	0	0	0
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	14,504	5,365	6,609	6,204	8,149	0	0	58,097	62,167	51,618
36	DUDLEY GROUP OF HOSPITALS	20,728			6,971	6,791	0	0	0	0	0
37	EALING HOSPITAL	7,113		2,562	4,032	4,186	0	23,786	0	24,821	0
38	EAST HERFORDSHIRE	9,323		4,604	4,400	3,989	0	0	0	35,000	0
39	EAST YORKSHIRE HOSPITALS	6,711			5,175	5,004	0	0	0	0	0
40	EASTBOURNE HOSPITALS	7,140		2,516	2,503	2,450	D	35,187	0	35,500	0
41	EPSOM	7,926	2,344	2,204	2,511	2,346	0	0	0	0	25,629
42	FREEMAN GROUP OF HOSPITALS	20,567					49,054	49,662	50,378	0	49,057
43	FRIMLEY PARK HOSPITAL	10,292		3,491	3,326	3,408	0	29,232	31,910	32,433	0
44	FURNESS HOSPITALS	4,807			1,768	1,767	0	0	0	0	0
45	GATESHEAD HOSPITALS	3,515			2,770	2,651	0	0	28,765	29,473	0
46	GEORGE ELIOT HOSPITAL	10,647			4,368	4,639	0	0	0	0	0
47	GLENFIELD HOSPITAL	6,253					0	0	0	0	0
48	GLOUCESTERSHIRE ROYAL	10,919			5,290	5,523	0	0	47,900	0	0
49	GOOD HOPE HOSPITAL	8,304			5,734	6,064	0	0	0	41,542	0
50	GUY'S AND ST THOMAS' HOSPITAL	27,310			7,943	7,976	0	78,944	78,954	90,025	0
51	HALTON GENERAL HOSPITAL	7,495					0	14,626	15,591	16,369	0
52	HAMMERSMITH HOSPITALS	25,863				10,235	0	0	0	0	0
53	HARTLEPOOL AND PETERLEE HOSPITALS	10,489				6,716	0	0	0	0	0
54	HAVERING HOSPITALS	18,479			5,294	5,271	0	75,383	83,485	89,735	0
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS	12,313		3,702	11,635	11,515					0
56	HEREFORD HOSPITALS	8,598			4,078	4,202	0	0	0	0	0
57	HILLINGDON HOSPITAL	7,695	4,824	5,092	5,306	5,385	0	0	0	0	29,999
58	HINCHINGBROKE	9,310		3,251	3,373	3,204	0	0	26,223	27,469	0
59	HORTON GENERAL HOSPITAL	2,934			2,089	1,657	0	0	0	0	0
60	IPSWICH HOSPITAL	10,875			4,341	4,458	0	0	0	0	0
61	JAMES PAGET HOSPITAL	11,969			3,019	3,026	0	0	36,140	47,057	0
62	KENT & CANTERBURY HOSPITALS	13,035			2,906	2,864	0	0	35,000	0	0
63	KENT AND SUSSEX WEALD	9,447				3,978	0	0	0	0	0
64	KETTERING GENERAL HOSPITAL	11,120			6,550	6,745	0	0	0	0	0
65	KING'S	16,010			6,041	6,112	0	0	0	52,196	0
66	KING'S LYNN & WISBECH HOSPITALS	8,965		5,659	3,272	3,162	0	0	33,617	0	0
67	KINGSOTN HOSPITAL	12,957	4,048	4,629	4,888	5,393	31,288	34,190	32,340	32,558	33,770
68	LANCASTER ACUTE HOSPITALS	11,999		2,522	2,449	2,214	32,699	33,054	33,745	36,000	0
69	LEICESTER GENERAL HOSPITAL	14,582			7,795	7,482	0	45,891	50,476	55,979	0
70	LEICESTER ROYAL INFIRMARY	23,986			10,164	13,658	0	0	79,941	91,589	0
71	LEWISHAM HOSPITAL	8,572			3,858	4,007	0	0	35,047	33,723	0
72	LINCOLN HOSPITALS	7,729				4,176	0	0	0	0	0
73	LOUTH AND DISTRICT	2,106					0	0	0	0	0
74	LUTON AND DUNSTABLE HOSPITAL	8,836		7,320	6,995	6,658	0	0	0	0	0
75	MAYDAY	13,239			6,273	5,801	0	0	45,317	46,848	0
76	MEDWAY	7,311			7,757	7,708	0	0	0	0	0
77	MID CHESHIRE HOSPITALS	12,509	4,245	4,200	4,383	4,582	40,051	40,647	41,424	45,620	40,278
78	MID ESSEX HOSPITALS	6,866		5,008	5,014	5,012	0	0	0	0	0
79	MID KENT	9,381			4,378	4,835	0	0	0	0	0
80	MID STAFFORDSHIRE GENERAL HOSPITALS	9,817			3,476	3,146	0	0	0	0	0
81	MILTON KEYNES GENERAL	5,459		3,702	4,005	3,940	24,000	25,477	25,912	28,255	0

	A	BO	BP	BQ	BR	BS	BT	BU	BV	BW	BX
1							Total Episodes - In accounts				To
2	NAME	DAY CASES FCE	Obstetrics FCE	Obstetrics FCE	Obstetrics FCE	Obstetrics FCE	EPISODES FCE	EPISODES FCE	EPISODES FCE	EPISODES FCE	EPISODES FCE
3		Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92
4		1994/95	1991/92	1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	1991/92
82	MOUNT VERNON & WATFORD HOSPITALS	21,435				3,075	0	0	0	0	19,416
83	NEWHAM	10,748			10,301	11,009	0	0	0	0	0
84	NORFOLK & NORWICH	22,750			6,191	6,254	0	0	0	0	0
85	NORTH DURHAM ACUTE HOSPITALS	8,802			4,116	3,989	0	0	0	0	0
86	NORTH HAMPSHIRE HOSPITALS	12,742				4,059	0	0	0	0	0
87	NORTH MIDDLESEX HOSPITAL	12,456	4,997	5,032	5,249	5,221	0	0	0	0	35,040
88	NORTH STAFFORDSHIRE HOSPITAL	20,141			12,907	12,926	0	0	0	0	0
89	NORTHAMPTON GENERAL HOSPITAL	14,909			6,183	7,165	0	0	0	0	0
90	NORTHERN GENERAL HOSPITAL	9,362	6,210	5,707	5,853	5,718	0	0	0	0	50,872
91	NORTHWICK PARK & ST MARK'S	10,979			5,118	5,513	0	0	0	0	0
92	NOTTINGHAM CITY HOSPITAL	13,748		8,287	8,536	8,414	0	0	59,368	65,921	0
93	OXFORD RADCLIFFE HOSPITAL	15,135			9,604	8,537	0	0	0	0	0
94	PETERBOROUGH HOSPITALS	10,428			7,916	4,466	0	44,021	46,173	48,326	0
95	PILGRIM HEALTH	8,604			2,894	2,881	0	0	0	0	0
96	PINDERFIELDS HOSPITALS	11,148			3,074	2,815	0	0	0	0	0
97	PLYMOUTH HOSPITALS	17,126			6,515	6,357	0	0	0	0	0
98	PONTEFRACT HOSPITALS	8,497			4,767	4,615	0	0	0	0	0
99	POOLE HOSPITAL	12,263		5,784	5,317	6,060	37,491	39,980	44,073	49,000	0
100	PORTSMOUTH HOSPITALS	14,265				16,642	0	0	0	0	0
101	PRESTON ACUTE HOSPITALS	20,008			8,767	7,913	0	0	0	0	0
102	PRINCESS ROYAL HOSPITAL	5,389					0	0	0	0	0
103	QUEEN MARY'S SIDCUP	6,301			5,825	6,254	0	0	0	0	0
104	QUEEN VICTORIA HOSPITAL	3,919					0	0	0	0	0
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	15,283			6,988	6,686	0	0	0	0	0
106	RADCLIFFE INFIRMARY	2,040					0	0	0	0	0
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	1,152					0	0	0	0	0
108	ROCHDALE	11,090		2,971	2,763	2,842	32,578	33,953	34,004	36,036	0
109	ROTHERHAM GENERAL HOSPITALS	6,534			7,178	3,668	0	0	0	0	0
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	13,931			6,031	6,358	0	0	0	0	0
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	18,969		994	1,069	1,025	0	0	50,000	56,000	0
112	ROYAL BROMPTON HOSPITAL	6,184					0	0	0	0	0
113	ROYAL CORNWALL HOSPITALS	11,940		4,980	5,119	4,868	0	0	60,183	58,903	0
114	ROYAL DEVON AND EXETER	14,705			6,351	6,688	0	0	59,202	67,122	0
115	ROYAL FREE HAMPSTEAD	9,873	3,136	4,994	4,169	4,413	37,703	47,612	53,731	58,501	39,863
116	ROYAL HULL HOSPITALS	13,745			9,971	9,178	0	0	0	0	0
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	15,775					0	50,580	54,020	58,097	47,978
118	ROYAL SHREWSBURY HOSPITALS	9,653			5,659	10,219	0	0	0	0	0
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	8,535	3,099	3,502	3,596	3,757	0	0	0	0	35,275
120	ROYAL UNITED HOSPITAL BATH	12,758					0	0	0	0	0
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	27,868			5,851	9,180	0	0	0	0	0
122	ROYAL WEST SUSSEX	6,646			2,843	2,726	0	0	0	0	0
123	ROYAL WOLVERHAMPTON HOSPITALS	14,462			8,811	8,883	0	0	0	0	0
124	SALFORD ROYAL HOSPITALS	13,566			5,370	5,924	0	0	0	0	0
125	SCUNTHORPE & GOOLE HOSPITALS	8,832			2,693	2,727	0	0	0	0	0
126	SOUTH KENT HOSPITALS	10,004			5,002	4,536	0	0	0	0	0
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	22,026				5,191	0	0	0	0	0
128	SOUTH TEES ACUTE HOSPITALS	20,809			6,693	6,683	69,362	72,000	76,000	84,100	0
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	9,040			2,534	2,776	0	0	0	0	0
130	SOUTHAMPTON UNIVERSITY HOSPITALS	30,669			8,157	10,443	0	0	0	0	0
131	SOUTHEND	13,812	7,330	9,859	9,991	10,372	0	0	0	0	49,995
132	SOUTHPORT AND FORMBY	9,184		1,974	2,296	2,201	0	0	0	0	0
133	ST ALBANS AND HEMEL HEMPSTEAD	8,292			5,723	5,745	0	0	0	0	0
134	ST GEORGE'S	19,177			5,985	5,896	0	62,727	64,694	67,650	0
135	ST HELENS AND KNOWSLEY HOSPITALS	15,183	4,571	5,026	4,780	5,073	0	0	0	0	51,489
136	ST HELIER	14,392	7,628	9,452	8,917	8,290	0	0	0	0	44,979
137	ST JAMES'S UNIVERSITY HOSPITAL	29,008	7,109	9,289	9,581	9,722	33,580	39,091	42,878	47,008	71,235
138	ST MARY'S (IoW)	5,517			1,795	1,719	0	0	22,162	22,538	0
139	ST MARY'S	21,323			5,812	5,209	0	53,300	50,500	57,023	0
140	STOCKPORT ACUTE SERVICES	17,025					0	0	0	0	0
141	STOKE MANDEVILLE HOSPITAL	8,535			2,980	3,505	0	0	0	0	0
142	SWINDON AND MARLBOROUGH	8,913			5,035	5,197	0	0	0	0	0
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	10,882			4,922	4,803	0	0	0	0	0
144	THANET	7,531			2,139	2,106	0	0	24,749	26,976	0
145	UNITED LEEDS TEACHING HOSPITALS	19,295	7,775	8,028	7,854	10,230	0	0	0	0	74,571
146	UNIVERSITY COLLEGE LONDON HOSPITALS	14,015				4,907	0	0	0	0	0
147	WALSALL HOSPITALS	8,011			4,839	3,975	0	0	44,840	43,100	38,283
148	WALSGRAVE HOSPITALS	15,766			5,874	5,710	0	0	0	0	0
149	WARRINGTON HOSPITAL	8,973			6,664	7,482	0	0	0	0	0
150	WEST DORSET GENERAL HOSPITALS	7,817	2,577	2,704	2,684	2,575	0	0	0	0	26,322
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	12,140			3,329	2,738	0	0	0	0	0
152	WEST SUFFOK HOSPITALS	7,285			4,308	4,430	0	139,444	158,631	166,326	0
153	WESTMORLAND HOSPITALS	3,153			1,024		0	8,945	10,122	10,665	0
154	WHITTINGTON HOSPITAL	9,215			5,004	5,429	0	0	0	0	0
155	WINCHESTER & EASTLEIGH	3,285			3,063		0	0	0	0	0
156	WIRRAL HOSPITAL	21,397	6,852	7,435	7,963	8,014	0	68,998	75,824	82,728	71,478
157	WORTHING & SOUTHLANDS HOSPITALS	10,416			4,569	4,895	0	0	0	0	0

	A	BY	BZ	CA	CB	CC	CD	CE	CF	CG	CH
1		al Episodes - In other sources DoH			INCOME DEFLATED BY 3%p.a (i.e. 91/92 prices)						
2	NAME	EPISODES FCE	EPISODES FCE	EPISODES FCE	£k	£k	£k	£k	REAL INCOME CHANGE	REAL INCOME CHANGE	REAL INCOME CHANGE
3		Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92-93	Mar 93-94	Mar 94-95
4		1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	£k	£k	£k
5											
6	ADDENBROOKE'S	0	63,760	71,562	0	0	119,280	123,008	0	119,280	3,728
7	AIREDALE	35,145	35,601	37,977	0	53,660	54,004	55,080	53,660	343	1,076
8	ALEXANDRA	0	25,150	28,169	0	0	0	29,929	0	0	29,929
9	BARNSLEY DISTRICT GENERAL HOSPITAL	0	41,781	43,327	0	0	45,521	45,756	0	45,521	235
10	BASILDON & THURROCK GENERAL HOSPITALS	42,857	45,719	49,873	0	63,843	61,685	62,719	63,843	-2,158	1,033
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	18,351	19,319	19,587	0	30,446	31,189	32,322	30,446	743	1,133
12	BEDFORD HOSPITAL	32,118	35,108	35,844	0	33,842	39,006	39,604	33,842	5,164	598
13	BIRMINGHAM HEARTLANDS HOSPITAL	0	53,302	58,410	0	60,629	69,636	79,799	60,629	9,007	10,163
14	BISHOP AUCKLAND HOSPITALS	0	25,903	26,792	0	0	0	29,551	0	0	29,551
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	0	54,850	62,091	0	0	0	0	0	0	0
16	BOLTON HOSPITALS	0	52,125	53,709	0	0	0	0	0	0	0
17	BRADFORD HOSPITALS	83,218	85,113	89,887	78,169	86,238	87,890	90,613	8,069	1,653	2,723
18	BRIGHTON	0	54,584	56,531	0	0	76,969	75,646	0	76,969	-1,323
19	BROADGREEN HOSPITAL	23,956	23,043	21,078	38,587	40,757	38,895	35,153	2,170	-1,863	-3,741
20	BROMLEY HOSPITALS	0	43,157	44,513	0	0	62,145	59,914	0	62,145	-2,230
21	BURTON HOSPITALS	0	32,778	35,587	0	0	44,235	43,405	0	44,235	-830
22	CARLISLE HOSPITALS	0	34,361	34,612	0	0	0	0	0	0	0
23	CENTRAL MIDDLESEX HOSPITAL	28,832	26,155	29,663	48,223	47,934	45,483	43,128	-289	-2,450	-2,355
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	60,457	67,907	68,713	0	109,480	114,583	116,126	109,480	5,103	1,543
25	CHASE FARM HOSPITALS	0	35,910	39,124	0	0	43,293	43,075	0	43,293	-217
26	CHELSEA & WESTMINSTER	0	0	36,868	0	0	0	0	0	0	0
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	0	47,633	49,110	0	0	52,005	51,379	0	52,005	-626
28	CITY HOSPITAL	0	54,558	67,247	0	0	0	0	0	0	0
29	CITY HOSPITAL SUNDERLAND	0	70,379	69,667	0	0	0	0	0	0	0
30	CRAWLEY HORSHAM	0	23,229	24,752	0	0	41,188	39,838	0	41,188	-1,350
31	DARLINGTON MEMORIAL HOSPITAL	0	26,380	27,290	0	0	0	0	0	0	0
32	DARTFORD AND GRAVESHAM	0	35,287	35,379	0	0	0	0	0	0	0
33	DERBY CITY GENERAL HOSPITAL	0	38,807	45,466	0	0	39,428	42,633	0	39,428	3,204
34	DERBYSHIRE ROYAL INFIRMARY	0	37,056	37,465	0	0	0	0	0	0	0
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	56,107	61,540	65,831	58,673	61,706	63,101	65,095	3,033	1,395	1,995
36	DUDLEY GROUP OF HOSPITALS	0	68,795	72,496	0	0	0	0	0	0	0
37	EALING HOSPITAL	26,145	27,627	28,757	0	39,572	40,407	40,006	39,572	835	-401
38	EAST HERFORDSHIRE	30,157	32,268	34,940	0	54,236	54,567	54,525	54,236	331	-42
39	EAST YORKSHIRE HOSPITALS	0	27,094	27,609	0	0	37,849	37,887	0	37,849	38
40	EASTBOURNE HOSPITALS	33,927	37,988	38,847	0	55,268	57,885	58,446	55,268	2,617	561
41	EPSOM	27,083	27,259	28,777	43,582	46,103	44,696	44,156	2,521	-1,408	-540
42	FREEMAN GROUP OF HOSPITALS	49,813	50,377	59,345	68,504	72,193	73,087	84,462	3,689	894	11,375
43	FRIMLEY PARK HOSPITAL	33,486	37,495	39,240	0	39,833	42,255	45,320	39,833	2,422	3,065
44	FURNESS HOSPITALS	0	23,616	23,473	0	0	0	0	0	0	0
45	GATESHEAD HOSPITALS	0	28,583	29,473	0	0	39,136	40,614	0	39,136	1,478
46	GEORGE ELIOT HOSPITAL	0	37,538	40,803	0	0	0	0	0	0	0
47	GLENFIELD HOSPITAL	0	20,339	22,836	0	0	45,727	46,409	0	45,727	682
48	GLOUCESTERSHIRE ROYAL	0	51,614	51,981	0	0	60,452	61,980	0	60,452	1,528
49	GOOD HOPE HOSPITAL	0	38,110	41,542	0	0	40,722	43,345	0	40,722	2,623
50	GUY'S AND ST THOMAS' HOSPITAL	0	95,532	98,334	0	0	255,020	233,940	0	255,020	-21,080
51	HALTON GENERAL HOSPITAL	0	15,699	16,419	0	0	19,820	19,812	0	19,820	-8
52	HAMMERSMITH HOSPITALS	0	0	76,729	0	0	0	0	0	0	0
53	HARTLEPOOL AND PETERLEE HOSPITALS	0	0	33,119	0	0	0	0	0	0	0
54	HAVERING HOSPITALS	0	63,923	67,256	0	0	88,575	85,840	0	88,575	-2,736
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS	52,167	54,951	55,690	0	0	0	0	0	0	0
56	HEREFORD HOSPITALS	0	29,804	32,183	0	0	0	0	0	0	0
57	HILLINGDON HOSPITAL	29,288	32,365	33,524	46,539	48,426	48,281	47,924	1,887	-145	-357
58	HINCHINGBROKE	24,797	26,223	27,469	0	0	34,674	35,606	0	34,674	932
59	HORTON GENERAL HOSPITAL	0	14,477	14,757	0	0	18,245	17,852	0	18,245	-393
60	IPSWICH HOSPITAL	0	54,863	56,757	0	0	61,559	64,092	0	61,559	2,532
61	JAMES PAGET HOSPITAL	0	35,814	40,747	0	0	38,385	49,478	0	38,385	11,093
62	KENT & CANTERBURY HOSPITALS	0	38,375	41,526	0	0	46,780	49,471	0	46,780	2,692
63	KENT AND SUSSEX WEALD	0	0	35,787	0	0	0	0	0	0	0
64	KETTERING GENERAL HOSPITAL	0	43,373	46,160	0	0	0	0	0	0	0
65	KING'S	0	52,237	56,202	0	0	134,076	126,438	0	134,076	-7,638
66	KING'S LYNN & WISBECH HOSPITALS	34,004	36,147	38,126	0	48,472	48,489	49,138	48,472	17	649
67	KINGSTON HOSPITAL	38,836	34,706	37,783	41,902	43,708	40,040	41,629	1,806	-3,668	1,589
68	LANCASTER ACUTE HOSPITALS	36,002	35,658	37,132	0	40,665	39,443	39,008	40,665	-1,223	-435
69	LEICESTER GENERAL HOSPITAL	0	50,408	52,209	0	0	56,422	57,845	0	56,422	1,423
70	LEICESTER ROYAL INFIRMARY	0	84,411	96,760	0	0	101,363	107,673	0	101,363	6,309
71	LEWISHAM HOSPITAL	0	34,981	36,622	0	0	60,174	58,734	0	60,174	-1,440
72	LINCOLN HOSPITALS	0	0	39,817	0	0	0	0	0	0	0
73	LOUTH AND DISTRICT	0	7,206	7,488	0	0	0	0	0	0	0
74	LUTON AND DUNSTABLE HOSPITAL	43,251	45,594	46,122	0	49,929	48,904	50,599	49,929	-1,025	1,694
75	MAYDAY	0	49,207	49,722	0	0	60,476	60,050	0	60,476	-426
76	MEDWAY	0	38,388	40,980	0	0	0	0	0	0	0
77	MID CHESHIRE HOSPITALS	40,647	44,104	47,861	44,820	46,444	49,456	50,103	1,624	3,012	647
78	MID ESSEX HOSPITALS	42,872	44,271	45,738	0	60,609	58,604	60,007	60,609	-2,005	1,403
79	MID KENT	0	37,425	38,175	0	0	52,132	53,286	0	52,132	1,154
80	MID STAFFORDSHIRE GENERAL HOSPITALS	0	39,668	41,184	0	0	53,495	51,212	0	53,495	-2,283
81	MILTON KEYNES GENERAL	28,763	31,355	31,199	0	35,804	36,296	37,602	35,804	492	1,306

	A	BY	BZ	CA	CB	CC	CD	CE	CF	CG	CH
1		al Episodes - In other sources DoH			INCOME DEFLATED BY 3%p.a (i.e. 91/92 prices)						
2	NAME	EPISODES FCE	EPISODES FCE	EPISODES FCE	£k	£k	£k	£k	REAL INCOME CHANGE	REAL INCOME CHANGE	REAL INCOME CHANGE
3		Mar 93	Mar 94	Mar 95	Mar 92	Mar 93	Mar 94	Mar 95	Mar 92-93	Mar 93-94	Mar 94-95
4		1992/93	1993/94	1994/95	1991/92	1992/93	1993/94	1994/95	£k	£k	£k
82	MOUNT VERNON & WATFORD HOSPITALS	22,625	24,636	58,813	0	0	0	0	0	0	0
83	NEWHAM	0	43,210	40,764	0	0	0	0	0	0	0
84	NORFOLK & NORWICH	0	85,906	97,225	0	0	0	0	0	0	0
85	NORTH DURHAM ACUTE HOSPITALS	0	43,950	47,725	0	0	0	0	0	0	0
86	NORTH HAMPSHIRE HOSPITALS	0	0	33,872	0	0	0	0	0	0	0
87	NORTH MIDDLESEX HOSPITAL	33,620	35,119	36,572	46,506	49,120	48,194	49,708	2,614	-926	1,514
88	NORTH STAFFORDSHIRE HOSPITAL	0	92,691	98,653	0	0	118,045	117,501	0	118,045	-544
89	NORTHAMPTON GENERAL HOSPITAL	0	53,142	57,160	0	0	0	0	0	0	0
90	NORTHERN GENERAL HOSPITAL	52,148	56,026	58,314	86,186	99,094	103,507	106,909	12,908	4,413	3,401
91	NORTHWICK PARK & ST MARK'S	0	38,760	41,115	0	0	63,121	72,667	0	63,121	9,546
92	NOTTINGHAM CITY HOSPITAL	60,990	64,894	70,839	0	88,785	100,378	103,327	88,785	11,593	2,949
93	OXFORD RADCLIFFE HOSPITAL	0	58,536	80,484	0	0	0	0	0	0	0
94	PETERBOROUGH HOSPITALS	0	50,442	52,615	0	0	57,193	56,973	0	57,193	-220
95	PILGRIM HEALTH	0	37,467	37,914	0	0	0	0	0	0	0
96	PINDERFIELDS HOSPITALS	0	40,199	41,991	0	0	56,417	57,826	0	56,417	1,409
97	PLYMOUTH HOSPITALS	0	78,955	82,133	0	0	0	0	0	0	0
98	PONTEFRACT HOSPITALS	0	34,129	35,773	0	0	36,850	36,266	0	36,850	-584
99	POOLE HOSPITAL	44,117	47,662	52,858	0	49,184	52,048	55,514	49,184	2,864	3,466
100	PORTSMOUTH HOSPITALS	0	0	89,131	0	0	0	0	0	0	0
101	PRESTON ACUTE HOSPITALS	0	71,574	72,469	0	0	0	0	0	0	0
102	PRINCESS ROYAL HOSPITAL	0	19,568	21,565	0	0	25,252	25,765	0	25,252	513
103	QUEEN MARY'S SIDCUP	0	30,761	32,493	0	0	40,459	40,003	0	40,459	-455
104	QUEEN VICTORIA HOSPITAL	0	8,898	10,636	0	0	0	0	0	0	0
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	0	80,659	90,272	0	0	105,752	112,686	0	105,752	6,933
106	RADCLIFFE INFIRMARY	0	12,525	13,557	0	0	30,300	31,419	0	30,300	1,119
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	0	5,889	6,859	0	0	0	0	0	0	0
108	ROCHDALE	35,856	35,780	37,828	0	54,755	54,409	64,558	54,755	-345	10,149
109	ROTHERHAM GENERAL HOSPITALS	0	47,009	44,269	0	0	55,146	58,463	0	55,146	3,317
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	0	63,331	64,035	0	0	77,690	78,867	0	77,690	1,177
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	44,359	53,141	55,987	0	60,600	61,397	64,578	60,600	798	3,181
112	ROYAL BROMPTON HOSPITAL	0	0	16,363	0	0	0	0	0	0	0
113	ROYAL CORNWALL HOSPITALS	56,184	63,342	62,198	0	71,670	72,096	74,372	71,670	425	2,276
114	ROYAL DEVON AND EXETER	0	63,087	67,122	0	0	83,367	86,678	0	83,367	3,312
115	ROYAL FREE HAMPSTEAD	40,661	43,951	46,526	100,387	107,807	111,245	115,855	7,420	3,439	4,609
116	ROYAL HULL HOSPITALS	0	71,967	76,996	0	0	87,703	92,367	0	87,703	4,664
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	51,130	54,684	58,097	88,665	91,229	92,108	94,504	2,564	878	2,396
118	ROYAL SHREWSBURY HOSPITALS	0	46,486	52,919	0	0	0	0	0	0	0
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	35,147	36,153	38,063	47,922	46,492	49,705	49,667	-1,430	3,213	-38
120	ROYAL UNITED HOSPITAL BATH	41,591	46,306	49,648	0	55,110	58,046	61,622	55,110	2,936	3,576
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	0	50,589	99,485	0	0	0	0	0	0	0
122	ROYAL WEST SUSSEX	0	26,809	28,640	0	0	0	0	0	0	0
123	ROYAL WOLVERHAMPTON HOSPITALS	0	57,929	73,559	0	0	0	0	0	0	0
124	SALFORD ROYAL HOSPITALS	0	49,148	49,084	0	0	0	0	0	0	0
125	SCUNTHORPE & GOOLE HOSPITALS	0	34,931	37,515	0	0	46,963	46,164	0	46,963	-799
126	SOUTH KENT HOSPITALS	0	41,548	43,354	0	0	0	0	0	0	0
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	0	0	83,144	0	0	0	0	0	0	0
128	SOUTH TEES ACUTE HOSPITALS	0	85,874	88,161	0	86,341	90,768	98,182	86,341	4,427	7,414
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	0	30,716	32,922	0	0	38,660	39,235	0	38,660	575
130	SOUTHAMPTON UNIVERSITY HOSPITALS	0	102,321	113,073	0	0	138,178	149,460	0	138,178	11,282
131	SOUTHEND	51,013	52,211	54,705	54,514	57,384	60,296	62,240	2,870	2,911	1,944
132	SOUTHPORT AND FORMBY	25,212	27,279	27,313	0	31,603	32,572	33,660	31,603	969	1,088
133	ST ALBANS AND HEMEL HEMPSTEAD	0	31,800	33,001	0	0	0	0	0	0	0
134	ST GEORGE'S	0	65,653	65,256	0	0	130,888	130,596	0	130,888	-291
135	ST HELENS AND KNOWSLEY HOSPITALS	54,182	54,888	60,693	76,498	77,743	78,806	79,733	1,245	1,063	927
136	ST HELIER	54,717	56,388	55,445	71,355	84,252	83,171	79,176	12,897	-1,081	-3,995
137	ST JAMES'S UNIVERSITY HOSPITAL	77,804	84,537	87,042	93,761	106,587	113,328	119,655	12,826	6,740	6,327
138	ST MARY'S (IoW)	0	24,107	23,652	0	0	32,774	33,116	0	32,774	342
139	ST MARY'S	0	57,033	54,689	0	0	101,605	101,901	0	101,605	296
140	STOCKPORT ACUTE SERVICES	0	45,006	47,459	0	0	0	0	0	0	0
141	STOKE MANDEVILLE HOSPITAL	0	35,519	36,383	0	0	0	0	0	0	0
142	SWINDON AND MARLBOROUGH	0	43,878	45,928	0	0	0	0	0	0	0
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	0	34,751	37,332	0	0	0	0	0	0	0
144	THANET	0	25,459	26,976	0	0	32,495	33,192	0	32,495	697
145	UNITED LEEDS TEACHING HOSPITALS	74,735	83,073	86,954	128,266	137,312	141,461	144,933	9,046	4,148	3,473
146	UNIVERSITY COLLEGE LONDON HOSPITALS	0	0	50,346	0	0	0	0	0	0	0
147	WALSALL HOSPITALS	40,345	48,671	45,897	52,192	54,146	55,169	56,511	1,954	1,022	1,342
148	WALSGRAVE HOSPITALS	0	74,268	77,615	0	0	92,731	93,929	0	92,731	1,197
149	WARRINGTON HOSPITAL	0	44,746	47,507	0	0	43,798	44,329	0	43,798	531
150	WEST DORSET GENERAL HOSPITALS	26,591	28,883	30,024	36,889	36,740	37,754	38,701	-149	1,014	947
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	0	29,935	32,590	0	0	47,694	45,777	0	47,694	-1,917
152	WEST SUFFOK HOSPITALS	0	29,982	32,528	0	0	43,519	45,410	0	43,519	1,891
153	WESTMORLAND HOSPITALS	0	10,919	11,430	0	0	14,390	15,011	0	14,390	621
154	WHITTINGTON HOSPITAL	0	37,079	39,056	0	0	64,900	62,351	0	64,900	-2,548
155	WINCHESTER & EASTLEIGH	0	31,150	31,074	0	0	0	0	0	0	0
156	WIRRAL HOSPITAL	72,870	79,788	86,441	84,598	88,314	89,029	89,948	3,716	715	920
157	WORTHING & SOUTHLANDS HOSPITALS	0	43,336	46,349	0	0	0	0	0	0	0

	A	CI	CJ	CK	CL	CM	CN	CO	CP	CQ	CR
1					Total Episodes - In accounts						
2	NAME	% REAL INCOME CHANGE	% REAL INCOME CHANGE	% REAL INCOME CHANGE	EPISODE VOLUME CHANGE	EPISODE VOLUME CHANGE	EPISODE VOLUME CHANGE	% EPISODE VOLUME CHANGE	% EPISODE VOLUME CHANGE	% EPISODE VOLUME CHANGE	DIFFERENCE BETWEEN annual account vols & doh vols
3		Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92
4											1991/92
5											
6	ADDENBROOKE'S	#DIV/0!	#DIV/0!	3.13%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
7	AIREDALE	#DIV/0!	0.64%	1.99%	1,048	630	2,376	3.00%	1.77%	6.26%	-33,923
8	ALEXANDRA	#DIV/0!	#DIV/0!	#DIV/0!	0	22,965	3,276	#DIV/0!	100.00%	12.48%	0
9	BARNSLEY DISTRICT GENERAL HOSPITAL	#DIV/0!	#DIV/0!	0.52%	37,475	1,159	2,125	100.00%	3.00%	5.21%	0
10	BASILDON & THURROCK GENERAL HOSPITALS	#DIV/0!	-3.38%	1.68%	2,224	2,705	4,101	5.17%	5.91%	8.23%	-40,806
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	#DIV/0!	2.44%	3.63%	0	17,952	326	#DIV/0!	100.00%	1.78%	0
12	BEDFORD HOSPITAL	#DIV/0!	15.26%	1.53%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
13	BIRMINGHAM HEARTLANDS HOSPITAL	#DIV/0!	14.86%	14.59%	0	49,037	-49,037	#DIV/0!	100.00%	#DIV/0!	0
14	BISHOP AUCKLAND HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
16	BOLTON HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
17	BRADFORD HOSPITALS	10.32%	1.92%	3.10%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	81,276
18	BRIGHTON	#DIV/0!	#DIV/0!	-1.72%	0	56,000	-4,527	#DIV/0!	100.00%	-8.79%	0
19	BROADGREEN HOSPITAL	5.62%	-4.57%	-9.62%	341	-23,956	21,078	1.42%	#DIV/0!	100.00%	0
20	BROMLEY HOSPITALS	#DIV/0!	#DIV/0!	-3.59%	0	39,600	8,251	#DIV/0!	100.00%	17.24%	0
21	BURTON HOSPITALS	#DIV/0!	#DIV/0!	-1.88%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
22	CARLISLE HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
23	CENTRAL MIDDLESEX HOSPITAL	-0.60%	-5.11%	-5.18%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	27,998
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	#DIV/0!	4.66%	1.35%	60,744	3,578	165	100.00%	5.56%	0.26%	0
25	CHASE FARM HOSPITALS	#DIV/0!	#DIV/0!	-0.50%	0	32,259	940	#DIV/0!	100.00%	2.83%	0
26	CHELSEA & WESTMINSTER	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	#DIV/0!	#DIV/0!	-1.20%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
28	CITY HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
29	CITY HOSPITAL SUNDERLAND	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
30	CRAWLEY HORSHAM	#DIV/0!	#DIV/0!	-3.28%	24,276	550	-1,790	100.00%	2.22%	-7.77%	0
31	DARLINGTON MEMORIAL HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
32	DARTFORD AND GRAVESHAM	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
33	DERBY CITY GENERAL HOSPITAL	#DIV/0!	#DIV/0!	8.13%	0	33,869	6,817	#DIV/0!	100.00%	16.76%	0
34	DERBYSHIRE ROYAL INFIRMARY	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	5.17%	2.26%	3.16%	0	58,097	4,070	#DIV/0!	100.00%	6.55%	51,618
36	DUDLEY GROUP OF HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	D	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
37	EALING HOSPITAL	#DIV/0!	2.11%	-0.99%	23,786	-23,786	24,821	100.00%	#DIV/0!	100.00%	0
38	EAST HERFORDSHIRE	#DIV/0!	0.61%	-0.08%	0	0	35,000	#DIV/0!	#DIV/0!	100.00%	0
39	EAST YORKSHIRE HOSPITALS	#DIV/0!	#DIV/0!	0.10%	0	0	D	#DIV/0!	#DIV/0!	#DIV/0!	0
40	EASTBOURNE HOSPITALS	#DIV/0!	4.74%	0.97%	35,187	-35,187	35,500	100.00%	#DIV/0!	100.00%	0
41	EPSOM	5.78%	-3.05%	-1.21%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	25,629
42	FREEMAN GROUP OF HOSPITALS	5.39%	1.24%	15.56%	598	726	-50,378	1.20%	1.44%	#DIV/0!	3
43	FRIMLEY PARK HOSPITAL	#DIV/0!	6.08%	7.25%	29,232	2,678	523	100.00%	8.39%	1.61%	0
44	FURNESS HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
45	GATESHEAD HOSPITALS	#DIV/0!	#DIV/0!	3.78%	0	28,765	708	#DIV/0!	100.00%	2.40%	0
46	GEORGE ELIOT HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
47	GLENFIELD HOSPITAL	#DIV/0!	#DIV/0!	1.49%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
48	GLOUCESTERSHIRE ROYAL	#DIV/0!	#DIV/0!	2.53%	0	47,900	-47,900	#DIV/0!	100.00%	#DIV/0!	0
49	GOOD HOPE HOSPITAL	#DIV/0!	#DIV/0!	6.44%	0	0	41,542	#DIV/0!	#DIV/0!	100.00%	0
50	GUY'S AND ST THOMAS' HOSPITAL	#DIV/0!	#DIV/0!	-8.27%	78,944	10	11,071	100.00%	0.01%	12.30%	0
51	HALTON GENERAL HOSPITAL	#DIV/0!	#DIV/0!	-0.04%	14,626	965	778	100.00%	6.19%	4.75%	0
52	HAMMERSMITH HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
53	HARTLEPOOL AND PETERLEE HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
54	HAVERING HOSPITALS	#DIV/0!	#DIV/0!	-3.09%	75,383	8,102	2,250	100.00%	9.70%	2.62%	0
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
56	HEREFORD HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
57	HILLINGDON HOSPITAL	4.06%	-0.30%	-0.74%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	29,999
58	HINCHINGBROKE	#DIV/0!	#DIV/0!	2.69%	0	26,223	1,246	#DIV/0!	100.00%	4.54%	0
59	HORTON GENERAL HOSPITAL	#DIV/0!	#DIV/0!	-2.15%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
60	IPSWICH HOSPITAL	#DIV/0!	#DIV/0!	4.11%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
61	JAMES PAGET HOSPITAL	#DIV/0!	#DIV/0!	28.90%	0	38,140	8,917	#DIV/0!	100.00%	18.95%	0
62	KENT & CANTERBURY HOSPITALS	#DIV/0!	#DIV/0!	5.75%	0	35,000	-35,000	#DIV/0!	100.00%	#DIV/0!	0
63	KENT AND SUSSEX WEALD	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
64	KETTERING GENERAL HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
65	KING'S	#DIV/0!	#DIV/0!	-5.70%	0	0	52,196	#DIV/0!	#DIV/0!	100.00%	0
66	KING'S LYNN & WISBECH HOSPITALS	#DIV/0!	0.04%	1.34%	0	33,617	-33,617	#DIV/0!	100.00%	#DIV/0!	0
67	KINGSOTN HOSPITAL	4.31%	-8.39%	3.97%	2,902	-1,850	218	8.49%	-5.72%	0.67%	2,482
68	LANCASTER ACUTE HOSPITALS	#DIV/0!	-3.01%	-1.10%	355	691	2,255	1.07%	2.05%	6.26%	-32,699
69	LEICESTER GENERAL HOSPITAL	#DIV/0!	#DIV/0!	2.52%	45,891	4,585	5,503	100.00%	9.08%	9.83%	0
70	LEICESTER ROYAL INFIRMARY	#DIV/0!	#DIV/0!	6.22%	0	79,941	11,648	#DIV/0!	100.00%	12.72%	0
71	LEWISHAM HOSPITAL	#DIV/0!	#DIV/0!	-2.39%	0	35,047	-1,324	#DIV/0!	100.00%	-3.93%	0
72	LINCOLN HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
73	LOUTH AND DISTRICT	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
74	LUTON AND DUNSTABLE HOSPITAL	#DIV/0!	-2.05%	3.46%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
75	MAYDAY	#DIV/0!	#DIV/0!	-0.70%	0	45,317	1,529	#DIV/0!	100.00%	3.26%	0
76	MEDWAY	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
77	MID CHESHIRE HOSPITALS	3.62%	6.49%	1.31%	596	777	4,096	1.47%	1.88%	9.00%	227
78	MID ESSEX HOSPITALS	#DIV/0!	-3.31%	2.39%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
79	MID KENT	#DIV/0!	#DIV/0!	2.21%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
80	MID STAFFORDSHIRE GENERAL HOSPITALS	#DIV/0!	#DIV/0!	-4.27%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
81	MILTON KEYNES GENERAL	#DIV/0!	1.38%	3.60%	1,477	435	2,343	5.80%	1.58%	8.29%	-24,000

	A	CI	CJ	CK	CL	CM	CN	CO	CP	CQ	CR
1					Total Episodes - In accounts						
2	NAME	% REAL INCOME CHANGE	% REAL INCOME CHANGE	% REAL INCOME CHANGE	EPISODE VOLUME CHANGE	EPISODE VOLUME CHANGE	EPISODE VOLUME CHANGE	% EPISODE VOLUME CHANGE	% EPISODE VOLUME CHANGE	% EPISODE VOLUME CHANGE	DIFFERENCE BETWEEN annual account vols & doh vols
3		Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92
4											1991/92
5											
82	MOUNT VERNON & WATFORD HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	19,416
83	NEWHAM	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
84	NORFOLK & NORWICH	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
85	NORTH DURHAM ACUTE HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
86	NORTH HAMPSHIRE HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
87	NORTH MIDDLESEX HOSPITAL	5.62%	-1.89%	3.14%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	35,040
88	NORTH STAFFORDSHIRE HOSPITAL	#DIV/0!	#DIV/0!	-0.46%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
89	NORTHAMPTON GENERAL HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
90	NORTHERN GENERAL HOSPITAL	14.98%	4.45%	3.29%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	50,872
91	NORTHWICK PARK & ST MARK'S	#DIV/0!	#DIV/0!	15.12%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
92	NOTTINGHAM CITY HOSPITAL	#DIV/0!	13.06%	2.94%	0	59,368	6,553	#DIV/0!	100.00%	9.94%	0
93	OXFORD RADCLIFFE HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
94	PETERBOROUGH HOSPITALS	#DIV/0!	#DIV/0!	-0.38%	44,021	2,152	2,153	100.00%	4.66%	4.46%	0
95	PILGRIM HEALTH	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
96	PINDERFIELDS HOSPITALS	#DIV/0!	#DIV/0!	2.50%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
97	PLYMOUTH HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
98	PONTEFRACT HOSPITALS	#DIV/0!	#DIV/0!	-1.59%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
99	POOLE HOSPITAL	#DIV/0!	5.82%	6.66%	2,489	4,093	4,927	6.23%	9.29%	10.06%	-37,491
100	PORTSMOUTH HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
101	PRESTON ACUTE HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
102	PRINCESS ROYAL HOSPITAL	#DIV/0!	#DIV/0!	2.03%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
103	QUEEN MARY'S SIDCUP	#DIV/0!	#DIV/0!	-1.13%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
104	QUEEN VICTORIA HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	#DIV/0!	#DIV/0!	6.56%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
106	RADCLIFFE INFIRMARY	#DIV/0!	#DIV/0!	3.69%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
108	ROCHDALE	#DIV/0!	-0.63%	18.65%	1,375	51	2,032	4.05%	0.15%	5.64%	-32,578
109	ROTHERHAM GENERAL HOSPITALS	#DIV/0!	#DIV/0!	6.01%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	#DIV/0!	#DIV/0!	1.51%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	#DIV/0!	1.32%	5.18%	0	50,000	6,000	#DIV/0!	100.00%	10.71%	0
112	ROYAL BROMPTON HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
113	ROYAL CORNWALL HOSPITALS	#DIV/0!	0.59%	3.16%	0	60,183	-1,280	#DIV/0!	100.00%	-2.17%	0
114	ROYAL DEVON AND EXETER	#DIV/0!	#DIV/0!	3.97%	0	59,202	7,920	#DIV/0!	100.00%	11.80%	0
115	ROYAL FREE HAMPSTEAD	7.39%	3.19%	4.14%	9,909	6,119	4,770	20.81%	11.39%	8.15%	2,160
116	ROYAL HULL HOSPITALS	#DIV/0!	#DIV/0!	5.32%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	2.89%	0.96%	2.60%	50,580	3,440	4,077	100.00%	6.37%	7.02%	47,978
118	ROYAL SHREWSBURY HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	-2.98%	6.91%	-0.08%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	35,275
120	ROYAL UNITED HOSPITAL BATH	#DIV/0!	5.33%	6.16%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
122	ROYAL WEST SUSSEX	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
123	ROYAL WOLVERHAMPTON HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
124	SALFORD ROYAL HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
125	SCUNTHORPE & GOOLE HOSPITALS	#DIV/0!	#DIV/0!	-1.70%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
126	SOUTH KENT HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
128	SOUTH TEES ACUTE HOSPITALS	#DIV/0!	5.13%	8.17%	2,638	4,000	8,100	3.66%	5.26%	9.63%	-69,362
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	#DIV/0!	#DIV/0!	1.49%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
130	SOUTHAMPTON UNIVERSITY HOSPITALS	#DIV/0!	#DIV/0!	8.17%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
131	SOUTHEND	5.27%	5.07%	3.22%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	49,995
132	SOUTHPORT AND FORMBY	#DIV/0!	3.07%	3.34%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
133	ST ALBANS AND HEMEL HEMPSTEAD	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
134	ST GEORGE'S	#DIV/0!	#DIV/0!	-0.22%	62,727	1,957	2,956	100.00%	3.04%	4.37%	0
135	ST HELENS AND KNOWSLEY HOSPITALS	1.63%	1.37%	1.18%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	51,489
136	ST HELIER	18.07%	-1.28%	-4.80%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	44,979
137	ST JAMES'S UNIVERSITY HOSPITAL	13.68%	6.32%	5.58%	5,511	3,787	4,130	14.10%	8.83%	8.79%	37,655
138	ST MARY'S (IoW)	#DIV/0!	#DIV/0!	1.04%	0	22,162	376	#DIV/0!	100.00%	1.67%	0
139	ST MARY'S	#DIV/0!	#DIV/0!	0.29%	53,900	-2,800	6,523	100.00%	-5.54%	11.44%	0
140	STOCKPORT ACUTE SERVICES	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
141	STOKE MANDEVILLE HOSPITAL	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
142	SWINDON AND MARLBOROUGH	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
144	THANET	#DIV/0!	#DIV/0!	2.15%	0	24,749	2,227	#DIV/0!	100.00%	8.26%	0
145	UNITED LEEDS TEACHING HOSPITALS	7.05%	3.02%	2.45%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	74,571
146	UNIVERSITY COLLEGE LONDON HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
147	WALSALL HOSPITALS	3.74%	1.89%	2.43%	0	44,840	-1,740	#DIV/0!	100.00%	-4.04%	38,283
148	WALSGRAVE HOSPITALS	#DIV/0!	#DIV/0!	1.29%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
149	WARRINGTON HOSPITAL	#DIV/0!	#DIV/0!	1.21%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
150	WEST DORSET GENERAL HOSPITALS	-0.40%	2.76%	2.51%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	26,322
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	#DIV/0!	#DIV/0!	-4.02%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
152	WEST SUFFOK HOSPITALS	#DIV/0!	#DIV/0!	4.34%	139,444	19,187	7,695	100.00%	12.10%	4.63%	0
153	WESTMORLAND HOSPITALS	#DIV/0!	#DIV/0!	4.31%	8,945	1,177	543	100.00%	11.63%	6.09%	0
154	WHITTINGTON HOSPITAL	#DIV/0!	#DIV/0!	-3.93%	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
155	WINCHESTER & EASTLEIGH	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0
156	WIRRAL HOSPITAL	4.39%	0.81%	1.03%	68,998	6,826	6,904	100.00%	9.00%	8.36%	71,478
157	WORTHING & SOUTHLANDS HOSPITALS	#DIV/0!	#DIV/0!	#DIV/0!	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!	0

	A	CS	CT	CU	CV	CW	CX	CY	CZ	DA	DB
1					Total Episodes - In other sources DoH						
2	NAME	DIFFERENCE BETWEEN annual account vols & doh vols	DIFFERENCE BETWEEN annual account vols & doh vols	DIFFERENCE BETWEEN annual account vols & doh vols	EPISODE VOLUME CHANGE (inc obs)	EPISODE VOLUME CHANGE (inc obs)	EPISODE VOLUME CHANGE (inc obs)	% EPISODE VOLUME CHANGE (inc obs)	% EPISODE VOLUME CHANGE (inc obs)	% EPISODE VOLUME CHANGE (inc obs)	EPISODE VOLUME CHANGE (exc obs)
3		Mar 93	Mar 94	Mar 95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93
4		1992/93	1993/94	1994/95							
5											
6	ADDENBROOKE'S	0	63,760	71,562	0	63,760	7,802	#DIV/0!	#DIV/0!	12.24%	0
7	AIREDALE	174	0	0	35,145	456	2,376	#DIV/0!	1.30%	6.67%	32,277
8	ALEXANDRA	0	2,185	1,928	0	25,150	3,019	#DIV/0!	#DIV/0!	12.00%	0
9	BARNSLEY DISTRICT GENERAL HOSPITAL	-37,475	3,147	2,568	0	41,781	1,546	#DIV/0!	#DIV/0!	3.70%	0
10	BASILDON & THURROCK GENERAL HOSPITALS	-173	-16	37	42,857	2,862	4,154	#DIV/0!	6.68%	9.09%	37,516
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	18,351	1,367	1,309	18,351	968	268	#DIV/0!	5.27%	1.39%	16,423
12	BEDFORD HOSPITAL	32,118	35,108	35,844	32,118	2,990	736	#DIV/0!	9.31%	2.10%	29,102
13	BIRMINGHAM HEARTLANDS HOSPITAL	0	4,265	58,410	0	53,302	5,108	#DIV/0!	#DIV/0!	9.58%	0
14	BISHOP AUCKLAND HOSPITALS	0	25,903	26,792	0	25,903	889	#DIV/0!	#DIV/0!	3.43%	0
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	0	54,850	62,091	0	54,850	7,241	#DIV/0!	#DIV/0!	13.20%	0
16	BOLTON HOSPITALS	0	52,125	53,709	0	52,125	1,584	#DIV/0!	#DIV/0!	3.04%	0
17	BRADFORD HOSPITALS	83,218	85,113	89,887	1,942	1,895	4,774	2.39%	2.28%	5.61%	1,393
18	BRIGHTON	0	-1,416	5,058	0	54,584	1,947	#DIV/0!	#DIV/0!	3.57%	0
19	BROADGREEN HOSPITAL	0	23,043	0	341	-913	-1,965	1.44%	-3.81%	-8.53%	341
20	BROMLEY HOSPITALS	0	3,557	-3,338	0	43,157	1,356	#DIV/0!	#DIV/0!	3.14%	0
21	BURTON HOSPITALS	0	32,778	35,587	0	32,778	2,809	#DIV/0!	#DIV/0!	8.57%	0
22	CARLISLE HOSPITALS	0	34,361	34,612	0	34,361	251	#DIV/0!	#DIV/0!	0.73%	0
23	CENTRAL MIDDLESEX HOSPITAL	28,832	26,155	29,663	834	-2,677	3,508	2.98%	-9.28%	13.41%	527
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	-287	3,585	4,226	60,457	7,450	806	#DIV/0!	12.32%	1.19%	54,265
25	CHASE FARM HOSPITALS	0	3,651	5,925	0	35,910	3,214	#DIV/0!	#DIV/0!	8.95%	0
26	CHELSEA & WESTMINSTER	0	0	36,868	0	0	36,868	#DIV/0!	#DIV/0!	#DIV/0!	0
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	0	47,633	49,110	0	47,633	1,477	#DIV/0!	#DIV/0!	3.10%	0
28	CITY HOSPITAL	0	54,558	67,247	0	54,558	12,689	#DIV/0!	#DIV/0!	23.26%	0
29	CITY HOSPITAL SUNDERLAND	0	70,379	69,667	0	70,379	-712	#DIV/0!	#DIV/0!	-1.01%	0
30	CRAWLEY HORSHAM	-24,276	-1,597	1,716	0	23,229	1,523	#DIV/0!	#DIV/0!	6.56%	0
31	DARLINGTON MEMORIAL HOSPITAL	0	26,380	27,290	0	26,380	910	#DIV/0!	#DIV/0!	3.45%	0
32	DARTFORD AND GRAVESHAM	0	35,287	35,379	0	35,287	92	#DIV/0!	#DIV/0!	0.26%	0
33	DERBY CITY GENERAL HOSPITAL	0	4,938	4,780	0	38,807	6,659	#DIV/0!	#DIV/0!	17.16%	0
34	DERBYSHIRE ROYAL INFIRMARY	0	37,056	37,465	0	37,056	409	#DIV/0!	#DIV/0!	1.10%	0
35	DONCASTER ROYAL & MANDTAGU HOSPITAL	56,107	3,443	3,664	4,489	5,433	4,291	8.70%	9.68%	6.97%	4,245
36	DUDLEY GROUP OF HOSPITALS	0	68,795	72,496	0	68,795	3,701	#DIV/0!	#DIV/0!	5.38%	0
37	EALING HOSPITAL	2,359	27,627	3,946	26,145	1,482	1,140	#DIV/0!	5.67%	4.13%	23,583
38	EAST HERFORDSHIRE	30,157	32,268	-60	30,157	2,111	2,672	#DIV/0!	7.00%	8.28%	25,553
39	EAST YORKSHIRE HOSPITALS	0	27,094	27,609	0	27,094	515	#DIV/0!	#DIV/0!	1.90%	0
40	EASTBOURNE HOSPITALS	-1,260	37,988	3,347	33,927	4,061	859	#DIV/0!	11.97%	2.26%	31,411
41	EPSOM	27,083	27,259	28,777	1,454	176	1,518	5.67%	0.65%	5.57%	1,594
42	FREEMAN GROUP OF HOSPITALS	161	-1	59,345	756	564	8,968	1.54%	1.13%	17.80%	756
43	FRIMLEY PARK HOSPITAL	4,254	5,585	6,807	33,486	4,009	1,745	#DIV/0!	11.97%	4.65%	29,995
44	FURNESS HOSPITALS	0	23,616	23,473	0	23,616	-143	#DIV/0!	#DIV/0!	-0.61%	0
45	GATESHEAD HOSPITALS	0	-182	0	0	28,583	890	#DIV/0!	#DIV/0!	3.11%	0
46	GEORGE ELIOT HOSPITAL	0	37,538	40,803	0	37,538	3,265	#DIV/0!	#DIV/0!	8.70%	0
47	GLENFIELD HOSPITAL	0	20,339	22,836	0	20,339	2,497	#DIV/0!	#DIV/0!	12.28%	0
48	GLOUCESTERSHIRE ROYAL	0	3,714	51,981	0	51,614	367	#DIV/0!	#DIV/0!	0.71%	0
49	GOOD HOPE HOSPITAL	0	38,110	0	0	38,110	3,432	#DIV/0!	#DIV/0!	9.01%	0
50	GUY'S AND ST THOMAS' HOSPITAL	-78,944	16,578	8,309	0	95,532	2,802	#DIV/0!	#DIV/0!	2.93%	0
51	HALTON GENERAL HOSPITAL	-14,626	108	50	0	15,599	720	#DIV/0!	#DIV/0!	4.59%	0
52	HAMMERSMITH HOSPITALS	0	0	76,729	0	0	76,729	#DIV/0!	#DIV/0!	#DIV/0!	0
53	HARTLEPOOL AND PETERLEE HOSPITALS	0	0	33,119	0	0	33,119	#DIV/0!	#DIV/0!	#DIV/0!	0
54	HAVERING HOSPITALS	-75,383	-19,562	-18,479	0	63,923	3,333	#DIV/0!	#DIV/0!	5.21%	0
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS	52,167	54,951	55,690	52,167	2,784	739	#DIV/0!	5.34%	1.34%	48,465
56	HEREFORD HOSPITALS	0	29,804	32,183	0	29,804	2,379	#DIV/0!	#DIV/0!	7.98%	0
57	HILLINGDON HOSPITAL	29,288	32,365	33,524	-711	3,077	1,159	-2.37%	10.51%	3.58%	-979
58	HINCHINGBROKE	24,797	0	0	24,797	1,426	1,246	#DIV/0!	5.75%	4.75%	21,546
59	HORTON GENERAL HOSPITAL	0	14,477	14,757	0	14,477	280	#DIV/0!	#DIV/0!	1.93%	0
60	IPSWICH HOSPITAL	0	54,863	56,757	0	54,863	1,894	#DIV/0!	#DIV/0!	3.45%	0
61	JAMES PAGET HOSPITAL	0	-2,326	-6,310	0	35,814	4,933	#DIV/0!	#DIV/0!	13.77%	0
62	KENT & CANTERBURY HOSPITALS	0	3,375	41,526	0	38,375	3,151	#DIV/0!	#DIV/0!	8.21%	0
63	KENT AND SUSSEX WEALD	0	0	35,787	0	0	35,787	#DIV/0!	#DIV/0!	#DIV/0!	0
64	KETTERING GENERAL HOSPITAL	0	43,373	46,160	0	43,373	2,787	#DIV/0!	#DIV/0!	6.43%	0
65	KING'S	0	52,237	4,006	0	52,237	3,965	#DIV/0!	#DIV/0!	7.59%	0
66	KING'S LYNN & WISBECH HOSPITALS	34,004	2,530	38,126	34,004	2,143	1,979	#DIV/0!	6.30%	5.47%	28,345
67	KINGSOTN HOSPITAL	4,646	2,366	5,225	5,066	-4,130	3,077	15.00%	-10.63%	8.87%	4,485
68	LANCASTER ACUTE HOSPITALS	2,948	1,913	1,132	36,002	-344	1,474	#DIV/0!	-0.96%	4.13%	33,480
69	LEICESTER GENERAL HOSPITAL	-45,891	-68	-3,770	0	50,408	1,801	#DIV/0!	#DIV/0!	3.57%	0
70	LEICESTER ROYAL INFIRMARY	0	4,470	5,191	0	84,411	12,369	#DIV/0!	#DIV/0!	14.65%	0
71	LEWISHAM HOSPITAL	0	-66	2,899	0	34,981	1,641	#DIV/0!	#DIV/0!	4.69%	0
72	LINCOLN HOSPITALS	0	0	39,817	0	0	39,817	#DIV/0!	#DIV/0!	#DIV/0!	0
73	LOUTH AND DISTRICT	0	7,205	7,488	0	7,205	282	#DIV/0!	#DIV/0!	3.91%	0
74	LUTON AND DUNSTABLE HOSPITAL	43,251	45,594	46,122	43,251	2,343	528	#DIV/0!	5.42%	1.16%	35,931
75	MAYDAY	0	3,890	2,876	0	49,207	515	#DIV/0!	#DIV/0!	1.05%	0
76	MEDWAY	0	38,388	40,980	0	38,388	2,592	#DIV/0!	#DIV/0!	6.75%	0
77	MID CHESHIRE HOSPITALS	0	2,680	2,341	369	3,457	3,757	0.92%	8.50%	8.52%	414
78	MID ESSEX HOSPITALS	42,872	44,271	45,738	42,872	1,399	1,467	#DIV/0!	3.26%	3.31%	37,864
79	MID KENT	0	37,425	38,175	0	37,425	750	#DIV/0!	#DIV/0!	2.00%	0
80	MID STAFFORDSHIRE GENERAL HOSPITALS	0	39,668	41,154	0	39,668	1,486	#DIV/0!	#DIV/0!	3.75%	0
81	MILTON KEYNES GENERAL	3,286	5,443	2,944	28,763	2,592	-156	#DIV/0!	9.01%	-0.50%	25,061

	A	CS	CT	CU	CV	CW	CX	CY	CZ	DA	DB
1					Total Episodes - In other sources DoH						
2	NAME	DIFFERENCE BETWEEN annual account vols & doh vols	DIFFERENCE BETWEEN annual account vols & doh vols	DIFFERENCE BETWEEN annual account vols & doh vols	EPISODE VOLUME CHANGE (inc obs)	EPISODE VOLUME CHANGE (inc obs)	EPISODE VOLUME CHANGE (inc obs)	% EPISODE VOLUME CHANGE (inc obs)	% EPISODE VOLUME CHANGE (inc obs)	% EPISODE VOLUME CHANGE (inc obs)	EPISODE VOLUME CHANGE (exc obs)
3		Mar 93	Mar 94	Mar 95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95	Mar 92-93
4		1992/93	1993/94	1994/95							
5											
82	MOUNT VERNON & WATFORD HOSPITALS	22,625	24,636	58,813	3,209	2,011	34,177	16.53%	8.89%	138.73%	3,209
83	NEWHAM	0	43,210	40,764	0	43,210	-2,446	#DIV/0!	#DIV/0!	-5.66%	0
84	NORFOLK & NORWICH	0	85,906	97,225	0	85,906	11,319	#DIV/0!	#DIV/0!	13.18%	0
85	NORTH DURHAM ACUTE HOSPITALS	0	43,950	47,725	0	43,950	3,775	#DIV/0!	#DIV/0!	8.59%	0
86	NORTH HAMPSHIRE HOSPITALS	0	0	33,872	0	0	33,872	#DIV/0!	#DIV/0!	#DIV/0!	0
87	NORTH MIDDLESEX HOSPITAL	33,620	35,119	36,572	-1,420	1,499	1,453	-4.05%	4.46%	4.14%	-1,455
88	NORTH STAFFORDSHIRE HOSPITAL	0	92,691	98,653	0	92,691	5,962	#DIV/0!	#DIV/0!	6.43%	0
89	NORTHAMPTON GENERAL HOSPITAL	0	53,142	57,160	0	53,142	4,018	#DIV/0!	#DIV/0!	7.56%	0
90	NORTHERN GENERAL HOSPITAL	52,148	56,026	58,314	1,276	3,878	2,288	2.51%	7.44%	4.08%	1,779
91	NORTHWICK PARK & ST MARK'S	0	38,760	41,115	0	38,760	2,355	#DIV/0!	#DIV/0!	6.08%	0
92	NOTTINGHAM CITY HOSPITAL	60,990	5,526	4,918	60,990	3,904	5,945	#DIV/0!	6.40%	9.16%	52,703
93	OXFORD RADCLIFFE HOSPITAL	0	58,536	80,484	0	58,536	21,948	#DIV/0!	#DIV/0!	37.49%	0
94	PETERBOROUGH HOSPITALS	-44,021	4,269	4,289	0	50,442	2,173	#DIV/0!	#DIV/0!	4.31%	0
95	PILGRIM HEALTH	0	37,467	37,914	0	37,467	447	#DIV/0!	#DIV/0!	1.19%	0
96	PINDERFIELDS HOSPITALS	0	40,199	41,991	0	40,199	1,792	#DIV/0!	#DIV/0!	4.46%	0
97	PLYMOUTH HOSPITALS	0	78,955	82,133	0	78,955	3,178	#DIV/0!	#DIV/0!	4.03%	0
98	PONTEFRACT HOSPITALS	0	34,129	35,773	0	34,129	1,644	#DIV/0!	#DIV/0!	4.82%	0
99	POOLE HOSPITAL	4,137	3,589	3,858	44,117	3,545	5,196	#DIV/0!	8.04%	10.90%	38,333
100	PORTSMOUTH HOSPITALS	0	0	89,131	0	0	89,131	#DIV/0!	#DIV/0!	#DIV/0!	0
101	PRESTON ACUTE HOSPITALS	0	71,574	72,469	0	71,574	895	#DIV/0!	#DIV/0!	1.25%	0
102	PRINCESS ROYAL HOSPITAL	0	19,568	21,565	0	19,568	1,997	#DIV/0!	#DIV/0!	10.21%	0
103	QUEEN MARY'S SIDCUP	0	30,761	32,493	0	30,761	1,732	#DIV/0!	#DIV/0!	5.63%	0
104	QUEEN VICTORIA HOSPITAL	0	8,898	10,636	0	8,898	1,738	#DIV/0!	#DIV/0!	19.53%	0
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	0	80,659	90,272	0	80,659	9,613	#DIV/0!	#DIV/0!	11.92%	0
106	RADCLIFFE INFIRMARY	0	12,525	13,557	0	12,525	1,032	#DIV/0!	#DIV/0!	8.24%	0
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	0	5,889	6,859	0	5,889	970	#DIV/0!	#DIV/0!	16.47%	0
108	ROCHDALE	1,903	1,776	1,792	35,856	-76	2,048	#DIV/0!	-0.21%	5.72%	32,885
109	ROTHERHAM GENERAL HOSPITALS	0	47,009	44,269	0	47,009	-2,740	#DIV/0!	#DIV/0!	-5.83%	0
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	0	63,331	64,035	0	63,331	704	#DIV/0!	#DIV/0!	1.11%	0
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	44,359	3,141	-13	44,359	8,782	2,846	#DIV/0!	19.80%	5.36%	43,365
112	ROYAL BROMPTON HOSPITAL	0	0	16,363	0	0	16,363	#DIV/0!	#DIV/0!	#DIV/0!	0
113	ROYAL CORNWALL HOSPITALS	56,184	3,159	3,295	56,184	7,158	-1,144	#DIV/0!	12.74%	-1.81%	51,204
114	ROYAL DEVON AND EXETER	0	3,885	0	0	63,087	4,035	#DIV/0!	#DIV/0!	6.40%	0
115	ROYAL FREE HAMPSTEAD	-6,951	-9,780	-11,975	798	3,290	2,575	2.00%	8.09%	5.86%	-1,060
116	ROYAL HULL HOSPITALS	0	71,967	76,996	0	71,967	5,029	#DIV/0!	#DIV/0!	6.99%	0
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	550	664	0	3,152	3,554	3,413	6.57%	6.95%	6.24%	3,152
118	ROYAL SHREWSBURY HOSPITALS	0	46,486	52,919	0	46,486	6,433	#DIV/0!	#DIV/0!	13.84%	0
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	35,147	36,153	38,063	-128	1,006	1,910	-0.36%	2.86%	5.28%	-531
120	ROYAL UNITED HOSPITAL BATH	41,591	46,306	49,648	41,591	4,715	3,342	#DIV/0!	11.34%	7.22%	41,591
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	0	50,589	99,485	0	50,589	48,896	#DIV/0!	#DIV/0!	96.65%	0
122	ROYAL WEST SUSSEX	0	26,809	28,640	0	26,809	1,831	#DIV/0!	#DIV/0!	6.83%	0
123	ROYAL WOLVERHAMPTON HOSPITALS	0	57,929	73,559	0	57,929	15,630	#DIV/0!	#DIV/0!	26.98%	0
124	SALFORD ROYAL HOSPITALS	0	49,148	49,084	0	49,148	-64	#DIV/0!	#DIV/0!	-0.13%	0
125	SCUNTHORPE & GOOLE HOSPITALS	0	34,931	37,515	0	34,931	2,584	#DIV/0!	#DIV/0!	7.40%	0
126	SOUTH KENT HOSPITALS	0	41,548	43,354	0	41,548	1,806	#DIV/0!	#DIV/0!	4.35%	0
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	0	0	83,144	0	0	83,144	#DIV/0!	#DIV/0!	#DIV/0!	0
128	SOUTH TEES ACUTE HOSPITALS	-72,000	9,874	4,061	0	85,874	2,287	#DIV/0!	#DIV/0!	2.66%	0
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	0	30,716	32,922	0	30,716	2,206	#DIV/0!	#DIV/0!	7.18%	0
130	SOUTHAMPTON UNIVERSITY HOSPITALS	0	102,321	113,073	0	102,321	10,752	#DIV/0!	#DIV/0!	10.51%	0
131	SOUTHEND	51,013	52,211	54,705	1,018	1,198	2,494	2.04%	2.35%	4.78%	-1,511
132	SOUTHPORT AND FORMBY	25,212	27,279	27,313	25,212	2,067	34	#DIV/0!	8.20%	0.12%	23,238
133	ST ALBANS AND HEMEL HEMPSTEAD	0	31,800	33,001	0	31,800	1,201	#DIV/0!	#DIV/0!	3.78%	0
134	ST GEORGE'S	-62,727	959	-2,394	0	65,653	-397	#DIV/0!	#DIV/0!	-0.60%	0
135	ST HELENS AND KNOWSLEY HOSPITALS	54,182	64,888	60,693	2,693	706	5,805	5.23%	1.30%	10.58%	2,238
136	ST HELIER	54,717	56,388	55,445	9,738	1,671	-943	21.65%	3.05%	-1.67%	7,914
137	ST JAMES'S UNIVERSITY HOSPITAL	38,713	41,659	40,034	6,569	6,733	2,505	9.22%	8.65%	2.96%	4,389
138	ST MARY'S (IoW)	0	1,945	1,114	0	24,107	-455	#DIV/0!	#DIV/0!	-1.89%	0
139	ST MARY'S	-53,300	6,533	-2,334	0	57,033	-2,344	#DIV/0!	#DIV/0!	-4.11%	0
140	STOCKPORT ACUTE SERVICES	0	45,006	47,459	0	45,006	2,453	#DIV/0!	#DIV/0!	5.45%	0
141	STOKE MANDEVILLE HOSPITAL	0	35,519	36,383	0	35,519	864	#DIV/0!	#DIV/0!	2.43%	0
142	SWINDON AND MARLBOROUGH	0	43,878	45,928	0	43,878	2,050	#DIV/0!	#DIV/0!	4.67%	0
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	0	34,751	37,332	0	34,751	2,581	#DIV/0!	#DIV/0!	7.43%	0
144	THANET	0	710	0	0	25,459	1,517	#DIV/0!	#DIV/0!	5.96%	0
145	UNITED LEEDS TEACHING HOSPITALS	74,735	83,073	86,954	164	8,338	3,881	0.22%	11.16%	4.67%	-89
146	UNIVERSITY COLLEGE LONDON HOSPITALS	0	0	50,346	0	0	50,346	#DIV/0!	#DIV/0!	#DIV/0!	0
147	WALSALL HOSPITALS	40,345	3,831	2,797	2,062	8,326	-2,774	5.39%	20.64%	-5.70%	2,062
148	WALSGRAVE HOSPITALS	0	74,268	77,615	0	74,268	3,347	#DIV/0!	#DIV/0!	4.51%	0
149	WARRINGTON HOSPITAL	0	44,746	47,507	0	44,746	2,761	#DIV/0!	#DIV/0!	6.17%	0
150	WEST DORSET GENERAL HOSPITALS	26,591	26,883	30,024	269	2,292	1,141	1.02%	8.62%	3.95%	142
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	0	29,935	32,590	0	29,935	2,655	#DIV/0!	#DIV/0!	8.87%	0
152	WEST SUFFOK HOSPITALS	-139,444	-128,649	-133,798	0	29,982	2,546	#DIV/0!	#DIV/0!	8.49%	0
153	WESTMORLAND HOSPITALS	-8,945	797	765	0	10,919	511	#DIV/0!	#DIV/0!	4.68%	0
154	WHITTINGTON HOSPITAL	0	37,079	39,056	0	37,079	1,977	#DIV/0!	#DIV/0!	5.33%	0
155	WINCHESTER & EASTLEIGH	0	31,150	31,074	0	31,150	-76	#DIV/0!	#DIV/0!	-0.24%	0
156	WIRRAL HOSPITAL	3,872	3,964	3,713	1,392	6,918	6,653	1.95%	9.49%	8.34%	809
157	WORTHING & SOUTHLANDS HOSPITALS	0	43,336	46,349	0	43,336	3,013	#DIV/0!	#DIV/0!	6.95%	0

	A	DC	DD	DE	DF	DG
1		DoH Episodes minus Obstetrics Activity				
2	NAME	EPISODE VOLUME CHANGE (exc obs)	EPISODE VOLUME CHANGE (exc obs)	% EPISODE VOLUME CHANGE (exc obs)	% EPISODE VOLUME CHANGE (exc obs)	% EPISODE VOLUME CHANGE (exc obs)
3		Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95
4						
5						
6	ADDENBROOKE'S	55,920	7,307	#DIV/0!	#DIV/0!	13.07%
7	AIREDALE	173	1,876	#DIV/0!	0.54%	5.78%
8	ALEXANDRA	22,325	2,368	#DIV/0!	#DIV/0!	10.61%
9	BARNSLEY DISTRICT GENERAL HOSPITAL	38,110	1,589	#DIV/0!	#DIV/0!	4.17%
10	BASILDON & THURROCK GENERAL HOSPITALS	-1,767	4,202	#DIV/0!	-4.71%	11.75%
11	BASSETLAW HOSPITAL AND COMMUNITY SERVICES	873	238	#DIV/0!	5.32%	1.38%
12	BEDFORD HOSPITAL	3,064	903	#DIV/0!	10.53%	2.81%
13	BIRMINGHAM HEARTLANDS HOSPITAL	46,624	901	#DIV/0!	#DIV/0!	1.93%
14	BISHOP AUCKLAND HOSPITALS	22,888	-1,077	#DIV/0!	#DIV/0!	-4.71%
15	BLACKPOOL VICTORIA HOSPITAL COMMUNITY	49,339	7,224	#DIV/0!	#DIV/0!	14.64%
16	BOLTON HOSPITALS	45,338	1,265	#DIV/0!	#DIV/0!	2.79%
17	BRADFORD HOSPITALS	1,498	4,655	1.92%	2.02%	6.16%
18	BRIGHTON	48,548	1,965	#DIV/0!	#DIV/0!	4.05%
19	BROADGREEN HOSPITAL	-913	-1,965	1.44%	-3.81%	-8.53%
20	BROMLEY HOSPITALS	38,080	1,418	#DIV/0!	#DIV/0!	3.72%
21	BURTON HOSPITALS	28,758	2,434	#DIV/0!	#DIV/0!	8.46%
22	CARLISLE HOSPITALS	31,487	430	#DIV/01	#DIV/0!	1.37%
23	CENTRAL MIDDLESEX HOSPITAL	-2,123	2,637	2.15%	-8.46%	11.49%
24	CENTRAL SHEFFIELD UNIVERSITY HOSPITALS	7,319	980	#DIV/0!	13.49%	1.59%
25	CHASE FARM HOSPITALS	31,126	1,479	#DIV/0!	#DIV/0!	4.75%
26	CHELSEA & WESTMINSTER	0	33,553	#DIV/0!	#DIV/0!	#DIV/0!
27	CHESTERFIELD & NORTH DERBYSHIRE ROYAL HOSPI	42,428	1,651	#DIV/0!	#DIV/0!	3.89%
28	CITY HOSPITAL	49,176	12,747	#DIV/0!	#DIV/0!	25.92%
29	CITY HOSPITAL SUNDERLAND	64,116	-1,564	#DIV/0!	#DIV/0!	-2.44%
30	CRAWLEY HORSHAM	20,765	1,252	#DIV/0!	#DIV/0!	6.03%
31	DARLINGTON MEMORIAL HOSPITAL	24,474	845	#DIV/0!	#DIV/0!	3.45%
32	DARTFORD AND GRAVESHAM	30,927	686	#DIV/0!	#DIV/0!	2.22%
33	DERBY CITY GENERAL HOSPITAL	31,287	6,792	#DIV/0!	#DIV/0!	21.71%
34	DERBYSHIRE ROYAL INFIRMARY	37,056	409	#DIV/0!	#DIV/0!	1.10%
35	DONCASTER ROYAL & MANOTAGU HOSPITAL	5,838	2,346	9.38%	11.79%	4.24%
36	DUDLEY GROUP OF HOSPITALS	61,824	3,881	#DIV/0!	#DIV/0!	6.28%
37	EALING HOSPITAL	12	986	#DIV/0!	0.05%	4.18%
38	EAST HERFORDSHIRE	2,315	3,083	#DIV/0!	9.06%	11.06%
39	EAST YORKSHIRE HOSPITALS	21,919	686	#DIV/0!	#DIV/0!	3.13%
40	EASTBOURNE HOSPITALS	4,074	912	#DIV/0!	12.97%	2.57%
41	EPSOM	-131	1,683	6.85%	-0.53%	6.80%
42	FREEMAN GROUP OF HOSPITALS	564	8,968	1.54%	1.13%	17.80%
43	FRIMLEY PARK HOSPITAL	4,174	1,663	#DIV/0!	13.92%	4.87%
44	FURNESS HOSPITALS	21,848	-142	#DIV/0!	#DIV/0!	-0.65%
45	GATESHEAD HOSPITALS	25,813	1,009	#DIV/0!	#DIV/0!	3.91%
46	GEORGE ELIOT HOSPITAL	33,170	2,994	#DIV/0!	#DIV/0!	9.03%
47	GLENFIELD HOSPITAL	20,339	2,497	#DIV/0!	#DIV/0!	12.28%
48	GLOUCESTERSHIRE ROYAL	46,324	134	#DIV/01	#DIV/0!	0.29%
49	GOOD HOPE HOSPITAL	32,376	3,102	#DIV/0!	#DIV/0!	9.58%
50	GUY'S AND ST THOMAS' HOSPITAL	87,589	2,769	#DIV/0!	#DIV/0!	3.16%
51	HALTON GENERAL HOSPITAL	15,699	720	#DIV/01	#DIV/0!	4.59%
52	HAMMERSMITH HOSPITALS	0	65,494	#DIV/0!	#DIV/0!	#DIV/0!
53	HARTLEPOOL AND PETERLEE HOSPITALS	0	26,403	#DIV/0!	#DIV/0!	#DIV/0!
54	HAVERING HOSPITALS	58,629	3,356	#DIV/0!	#DIV/0!	5.72%
55	HEATHERWOOD AND WEXHAM PARK HOSPITALS	5,149	859	#DIV/0!	-10.62%	1.98%
56	HEREFORD HOSPITALS	25,726	2,255	#DIV/0!	#DIV/0!	8.77%
57	HILLINGDON HOSPITAL	2,863	1,080	-3.89%	11.83%	3.99%
58	HINCHINGBROKE	1,304	1,415	#DIV/0!	6.05%	6.19%
59	HORTON GENERAL HOSPITAL	12,388	712	#DIV/0!	#DIV/0!	5.75%
60	IPSWICH HOSPITAL	50,522	1,777	#DIV/0!	#DIV/0!	3.52%
61	JAMES PAGET HOSPITAL	32,795	4,926	#DIV/0!	#DIV/0!	15.02%
62	KENT & CANTERBURY HOSPITALS	35,469	3,193	#DIV/0!	#DIV/0!	9.00%
63	KENT AND SUSSEX WEALD	0	31,809	#DIV/0!	#DIV/0!	#DIV/0!
64	KETTERING GENERAL HOSPITAL	36,823	2,592	#DIV/0!	#DIV/0!	7.04%
65	KING'S	46,196	3,894	#DIV/0!	#DIV/0!	8.43%
66	KING'S LYNN & WISBECH HOSPITALS	4,530	2,089	#DIV/0!	15.98%	6.35%
67	KINGSOTN HOSPITAL	4,389	2,572	15.09%	-12.83%	8.63%
68	LANCASTER ACUTE HOSPITALS	-271	1,709	#DIV/0!	-0.81%	5.15%
69	LEICESTER GENERAL HOSPITAL	42,613	2,114	#DIV/0!	#DIV/0!	4.96%
70	LEICESTER ROYAL INFIRMARY	74,247	8,875	#DIV/0!	#DIV/0!	11.95%
71	LEWISHAM HOSPITAL	31,123	1,492	#DIV/0!	#DIV/0!	4.79%
72	LINCOLN HOSPITALS	0	35,641	#DIV/0!	#DIV/0!	#DIV/0!
73	LOUTH AND DISTRICT	7,206	282	#DIV/0!	#DIV/0!	3.91%
74	LUTON AND DUNSTABLE HOSPITAL	2,668	865	#DIV/0!	7.43%	2.24%
75	MAYDAY	42,934	987	#DIV/0!	#DIV/0!	2.30%
76	MEDWAY	30,631	2,641	#DIV/0!	#DIV/0!	8.62%
77	MID CHESHIRE HOSPITALS	3,274	3,558	1.15%	8.98%	8.96%
78	MID ESSEX HOSPITALS	1,393	1,469	#DIV/0!	3.68%	3.74%
79	MID KENT	33,047	293	#DIV/0!	#DIV/0!	0.89%
80	MID STAFFORDSHIRE GENERAL HOSPITALS	36,192	1,816	#DIV/0!	#DIV/0!	5.02%
81	MILTON KEYNES GENERAL	2,289	-91	#DIV/0!	9.13%	-0.33%

	A	DC	DD	DE	DF	DG
1		DoH Episodes minus Obstetrics Activity				
2	NAME	EPISODE VOLUME CHANGE (exc obs)	EPISODE VOLUME CHANGE (exc obs)	% EPISODE VOLUME CHANGE (exc obs)	% EPISODE VOLUME CHANGE (exc obs)	% EPISODE VOLUME CHANGE (exc obs)
3		Mar 93-94	Mar 94-95	Mar 92-93	Mar 93-94	Mar 94-95
4						
82	MOUNT VERNON & WATFORD HOSPITALS	2,011	31,102	16.53%	8.89%	126.25%
83	NEWHAM	32,909	-3,154	#DIV/0!	#DIV/0!	-9.58%
84	NORFOLK & NORWICH	79,715	11,256	#DIV/0!	#DIV/0!	14.12%
85	NORTH DURHAM ACUTE HOSPITALS	39,834	3,902	#DIV/0!	#DIV/0!	9.80%
86	NORTH HAMPSHIRE HOSPITALS	0	29,813	#DIV/0!	#DIV/0!	#DIV/0!
87	NORTH MIDDLESEX HOSPITAL	1,282	1,481	-4.84%	4.48%	4.96%
88	NORTH STAFFORDSHIRE HOSPITAL	79,784	5,943	#DIV/0!	#DIV/0!	7.45%
89	NORTHAMPTON GENERAL HOSPITAL	46,959	3,036	#DIV/0!	#DIV/0!	6.47%
90	NORTHERN GENERAL HOSPITAL	3,732	2,423	3.98%	8.04%	4.83%
91	NORTHWICK PARK & ST MARK'S	33,642	1,960	#DIV/0!	#DIV/0!	5.83%
92	NOTTINGHAM CITY HOSPITAL	3,655	6,067	#DIV/0!	6.94%	10.77%
93	OXFORD RADCLIFFE HOSPITAL	48,932	23,015	#DIV/0!	#DIV/0!	47.03%
94	PETERBOROUGH HOSPITALS	42,526	5,623	#DIV/0!	#DIV/0!	13.22%
95	PILGRIM HEALTH	34,573	460	#DIV/0!	#DIV/0!	1.33%
96	PINDERFIELDS HOSPITALS	37,125	2,051	#DIV/0!	#DIV/0!	5.52%
97	PLYMOUTH HOSPITALS	72,440	3,336	#DIV/0!	#DIV/0!	4.61%
98	PONTEFRACT HOSPITALS	29,362	1,796	#DIV/0!	#DIV/0!	6.12%
99	PDOLE HOSPITAL	4,012	4,453	#DIV/0!	10.47%	10.52%
100	PDRTSMOUTH HOSPITALS	0	72,489	#DIV/0!	#DIV/0!	#DIV/0!
101	PRESTON ACUTE HOSPITALS	62,807	1,749	#DIV/0!	#DIV/0!	2.78%
102	PRINCESS ROYAL HOSPITAL	19,568	1,997	#DIV/0!	#DIV/0!	10.21%
103	QUEEN MARY'S SIDCUP	24,936	1,303	#DIV/0!	#DIV/0!	5.23%
104	QUEEN VICTORIA HOSPITAL	9,898	1,738	#DIV/0!	#DIV/0!	19.53%
105	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSI	73,671	9,915	#DIV/0!	#DIV/0!	13.46%
106	RADCLIFFE INFIRMARY	12,525	1,032	#DIV/0!	#DIV/0!	8.24%
107	ROBERT JONES & AGNES HUNT ORTHOPAEDIC & DIS	5,889	970	#DIV/0!	#DIV/0!	16.47%
108	RDCHDALE	132	1,969	#DIV/0!	0.40%	5.96%
109	ROTHERHAM GENERAL HOSPITALS	39,831	770	#DIV/0!	#DIV/0!	1.93%
110	ROYAL BERKSHIRE AND BATTLE HOSPITALS	57,300	377	#DIV/0!	#DIV/0!	0.66%
111	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPI	8,707	2,890	#DIV/0!	20.08%	5.55%
112	RDYAL BROMPTON HOSPITAL	0	16,363	#DIV/0!	#DIV/0!	#DIV/0!
113	RDYAL CORNWALL HDSPITALS	7,019	-893	#DIV/0!	13.71%	-1.53%
114	ROYAL DEVON AND EXETER	56,736	3,698	#DIV/0!	#DIV/0!	6.52%
115	ROYAL FREE HAMPSTEAD	4,115	2,331	-2.89%	11.54%	5.86%
116	ROYAL HULL HOSPITALS	61,996	5,822	#DIV/0!	#DIV/0!	9.39%
117	ROYAL LIVERPOOL UNIVERSITY HOSPITAL	3,554	3,413	6.57%	6.95%	6.24%
118	ROYAL SHREWSBURY HOSPITALS	40,827	1,873	#DIV/0!	#DIV/0!	4.59%
119	ROYAL SURREY COUNTY & ST LUKE'S HOSPITALS	912	1,749	-1.65%	2.88%	5.37%
120	ROYAL UNITED HOSPITAL BATH	4,715	3,342	#DIV/0!	11.34%	7.22%
121	ROYAL VICTORIA INFIRMARY AND ASSOCIATED HOSPI	44,738	45,567	#DIV/0!	#DIV/0!	101.85%
122	ROYAL WEST SUSSEX	23,965	1,948	#DIV/0!	#DIV/0!	8.13%
123	ROYAL WOLVERHAMPTON HOSPITALS	49,118	15,558	#DIV/0!	#DIV/0!	31.67%
124	SALFORD ROYAL HOSPITALS	43,778	-618	#DIV/0!	#DIV/0!	-1.41%
125	SCUNTHORPE & GOOLE HOSPITALS	32,238	2,550	#DIV/0!	#DIV/0!	7.91%
126	SOUTH KENT HOSPITALS	36,546	2,272	#DIV/0!	#DIV/0!	6.22%
127	SOUTH MANCHESTER UNIVERSITY HOSPITALS	0	77,953	#DIV/0!	#DIV/0!	#DIV/0!
128	SOUTH TEES ACUTE HOSPITALS	79,181	2,297	#DIV/0!	#DIV/0!	2.90%
129	SOUTH WARWICKSHIRE GENERAL HOSPITALS	28,182	1,964	#DIV/0!	#DIV/0!	6.97%
130	SOUTHAMPTON UNIVERSITY HOSPITALS	94,164	8,466	#DIV/0!	#DIV/0!	8.99%
131	SOUTHEND	1,066	2,113	-3.54%	2.59%	5.00%
132	SOUTHPORT AND FORMBY	1,745	129	#DIV/0!	7.51%	0.52%
133	ST ALBANS AND HEMEL HEMPSTEAD	28,077	1,179	#DIV/0!	#DIV/0!	4.52%
134	ST GEORGE'S	59,668	-308	#DIV/0!	#DIV/0!	-0.52%
135	ST HELENS AND KNOWSLEY HOSPITALS	952	5,512	4.77%	1.94%	11.00%
136	ST HELIER	2,206	-316	21.19%	4.87%	-0.67%
137	ST JAMES'S UNIVERSITY HOSPITAL	8,441	2,364	6.84%	9.40%	3.15%
138	ST MARY'S (IoW)	22,312	-379	#DIV/0!	#DIV/0!	-1.70%
139	ST MARY'S	51,221	-1,741	#DIV/0!	#DIV/0!	-3.40%
140	STOCKPORT ACUTE SERVICES	45,006	2,453	#DIV/0!	#DIV/0!	5.45%
141	STOKE MANDEVILLE HOSPITAL	32,539	339	#DIV/0!	#DIV/0!	1.04%
142	SWINDON AND MARLBOROUGH	38,843	1,886	#DIV/0!	#DIV/0!	4.86%
143	TAMESIDE AND GLOSSOP ACUTE SERVICES	29,829	2,700	#DIV/0!	#DIV/0!	9.05%
144	THANET	23,320	1,550	#DIV/0!	#DIV/0!	6.65%
145	UNITED LEEDS TEACHING HOSPITALS	8,512	1,805	-0.13%	12.76%	2.00%
146	UNIVERSITY COLLEGE LONDON HOSPITALS	0	45,439	#DIV/0!	#DIV/0!	#DIV/0!
147	WALSALL HOSPITALS	3,487	-1,910	5.39%	8.54%	-4.36%
148	WALSGRAVE HOSPITALS	68,394	3,511	#DIV/0!	#DIV/0!	5.13%
149	WARRINGTON HOSPITAL	38,082	1,943	#DIV/0!	#DIV/0!	5.10%
150	WEST DORSET GENERAL HOSPITALS	2,312	1,250	0.60%	9.68%	4.77%
151	WEST MIDDLESEX UNIVERSITY HOSPITAL	26,606	3,246	#DIV/0!	#DIV/0!	12.20%
152	WEST SUFFOK HOSPITALS	25,674	2,424	#DIV/0!	#DIV/0!	9.44%
153	WESTMORLAND HOSPITALS	9,895	1,535	#DIV/0!	#DIV/0!	15.51%
154	WHITTINGTON HOSPITAL	32,075	1,552	#DIV/0!	#DIV/0!	4.84%
155	WINCHESTER & EASTLEIGH	28,087	2,987	#DIV/0!	#DIV/0!	10.63%
156	WIRRAL HOSPITAL	6,990	6,602	1.25%	9.77%	9.19%
157	WORTHING & SOUTHLANDS HOSPITALS	38,767	2,687	#DIV/0!	#DIV/0!	6.93%

Appendix 4 Summary of Results of Question 2

Appendix 4

Hospital A - Summary of Question 2 Results

Q2	Priorities Perceived as Belonging to :	Objective	Doctors Mean	Managers Mean	Difference	Total Mean
a	You	*Break-even financially*	3.78	1.92	1.9	2.68
b	You	*Maintain service volume*	2.22	2.54	-0.3	2.41
c	You	*Maintain service quality*	1.67	2.15	-0.5	1.95
d	You	*Expand revenue*	4.56	3.00	1.6	3.64
e	You	*Expand service volume*	3.67	3.54	0.1	3.59
f	You	*Expand service quality*	2.33	3.31	-1.0	2.91
g	You	*Other (specify)*	4.40	4.50	-0.1	4.45
h	Most Service/Business Managers	*Break-evan financially*	1.57	2.69	-1.1	2.30
j	Most Service/Business Managers	*Maintain service volume*	3.00	2.23	0.8	2.50
k	Most Service/Business Managers	*Maintain service quality*	2.14	2.54	-0.4	2.40
m	Most Service/Business Managers	*Expand revenue*	2.57	3.54	-1.0	3.20
n	Most Service/Business Managers	*Expand service volume*	3.14	3.62	-0.5	3.45
p	Most Service/Business Managers	*Expand service quality*	3.00	3.54	-0.5	3.35
q	Most Service/Business Managers	*Other (specify)*	6.67		6.7	5.38
r	Most Consultants	*Break-even financially*	4.25	4.85	-0.6	4.62
s	Most Consultants	*Maintain service volume*	2.63	2.85	-0.2	2.76
t	Most Consultants	*Maintain service quality*	1.88	2.46	-0.6	2.24
u	Most Consultants	*Expand revenue*	4.00	5.08	-1.1	4.67
v	Most Consultants	*Expand service volume*	3.38	3.38	0.0	3.38
w	Most Consultants	*Expand service quality*	2.50	3.00	-0.5	2.81
x	Most Consultants	*Other (specify)*	4.00	4.43	-0.4	4.30
y	The Trust Now	*Break-even financially*	1.75	1.77	-0.0	1.76
z	The Trust Now	*Maintain service volume*	3.63	2.85	0.8	3.14
aa	The Trust Now	*Maintain service quality*	2.50	2.92	-0.4	2.76
ab	The Trust Now	*Expand revenue*	2.75	2.69	0.1	2.71
ac	The Trust Now	*Expand service volume*	2.88	3.38	-0.5	3.19
ad	The Trust Now	*Expand service quality*	2.63	4.08	-1.5	3.52
ae	The Trust Now	*Other (specify)*	6.67		6.7	5.56
af	The Trust Ideally	*Break-even financially*	2.88	2.08	0.8	2.38
ag	The Trust Ideally	*Maintain service volume*	3.38	2.62	0.8	2.90
ah	The Trust Ideally	*Maintain service quality*	2.75	2.31	0.4	2.48
aj	The Trust Ideally	*Expand revenue*	2.75	2.46	0.3	2.57
ak	The Trust Ideally	*Expand service volume*	2.50	3.31	-0.8	3.00
am	The Trust Ideally	*Expand service quality*	1.75	2.77	-1.0	2.38
an	The Trust Ideally	*Other (specify)*	4.00		4.0	4.20

National Survey: Two Groupings : Doctors (1-3) and Managers (4-11)

(ρ value shown in table)

	Priorities Perceived as Belonging to :	Objective	ANOVA	2-tailed p Mann-Whitney
2 a	You	Break-even financially	0 **	0 **
2 b	You	Maintain service volume	0.0477 *	0.0545
2 c	You	Maintain service quality	0 **	0 **
2 d	You	Expand revenue	0 **	0 **
2 e	You	Expand service volume	0.6714	0.8662
2 f	You	Expand service quality	0 **	0 **
2 g	You	Other (specify)	0.0004**	.0022 **
2 h	Most Service/Business Managers	Break-even financially	0 **	0 **
2 j	Most Service/Business Managers	Maintain service volume	0.063	0.0045 **
2 k	Most Service/Business Managers	Maintain service quality	0 **	0 **
2 m	Most Service/Business Managers	Expand revenue	0 **	0 **
2 n	Most Service/Business Managers	Expand service volume	0.0536	0.0397 *
2 p	Most Service/Business Managers	Expand service quality	0 **	0 **
2 q	Most Service/Business Managers	Other (specify)	0 **	0 **
2 r	Most Consultants	Break-even financially	0.4216	0.4653
2 s	Most Consultants	Maintain service volume	0.0110*	0.0129 *
2 t	Most Consultants	Maintain service quality	0 **	0 **
2 u	Most Consultants	Expand revenue	0.0746	0.0709
2 v	Most Consultants	Expand service volume	0.0001 **	0 **
2 w	Most Consultants	Expand service quality	0.0150 *	0.0233 *
2 x	Most Consultants	Other (specify)	0.0004 **	0.0003 **
2 y	The Trust Now	Break-even financially	0.7873	0.8788
2 z	The Trust Now	Maintain service volume	0.1176	0.0096 **
2 aa	The Trust Now	Maintain service quality	0 **	0 **
2 ab	The Trust Now	Expand revenue	0.0116 *	0.01752*
2 ac	The Trust Now	Expand service volume	0.2815	0.2427
2 ad	The Trust Now	Expand service quality	0 **	0 **
2 ae	The Trust Now	Other (specify)	0 **	0 **
2 af	The Trust Ideally	Break-even financially	0 **	0 **
2 ag	The Trust Ideally	Maintain service volume	0.1143	0.0721
2 ah	The Trust Ideally	Maintain service quality	0.16	0.1976
2 aj	The Trust Ideally	Expand revenue	0.1026	0.2828
2 ak	The Trust Ideally	Expand service volume	0.391	0.6954
2 am	The Trust Ideally	Expand service quality	0.1298	0.1044
2 an	The Trust Ideally	Other (specify)	0.1566	0.1273

* = Significant at 0.05 level but not at 0.01

** = Significant at 0.01 level

National Survey: Eleven Separate Groupings of Respondents
(ρ value shown in table)

	Priorities Perceived as Belonging to :	*Objective*	ANOVA	Kruskal-Wallis H
2 a	You	*Break-even financially*	0 **	0 **
2 b	You	*Maintain service volume*	0.0535	0.0417 *
2 c	You	*Maintain service quality*	0 **	0 **
2 d	You	*Expand revenue*	0 **	0 **
2 e	You	*Expand service volume*	0.5338	0.527
2 f	You	*Expand service quality*	0 **	0 **
2 g	You	*Other (specify)*	0.0451 *	0.1062
2 h	Most Service/Business Managers	*Break-even financially*	0 **	0 **
2 j	Most Service/Business Managers	*Maintain service volume*	0.0169 *	0.0046 **
2 k	Most Service/Business Managers	*Maintain service quality*	0 **	0 **
2 m	Most Service/Business Managers	*Expand revenue*	0 **	0 **
2 n	Most Service/Business Managers	*Expand service volume*	0.111	0.075
2 p	Most Service/Business Managers	*Expand service quality*	0 **	0 **
2 q	Most Service/Business Managers	*Other (specify)*	0.0002 **	0.0003 **
2 r	Most Consultants	*Break-even financially*	0.3919	0.4619
2 s	Most Consultants	*Maintain service volume*	0.1279	0.1461
2 t	Most Consultants	*Maintain service quality*	0 **	0 **
2 u	Most Consultants	*Expand revenue*	0.3355	0.3949
2 v	Most Consultants	*Expand service volume*	0.0039 **	0.0020 **
2 w	Most Consultants	*Expand service quality*	0.148	0.1997
2 x	Most Consultants	*Other (specify)*	0.063	0.0742
2 y	The Trust Now	*Break-even financially*	0.0007 **	0 **
2 z	The Trust Now	*Maintain service volume*	0.36	0.0022 **
2 aa	The Trust Now	*Maintain service quality*	0 **	0 **
2 ab	The Trust Now	*Expand revenue*	0 **	0 **
2 ac	The Trust Now	*Expand service volume*	0.0007 **	0.0013 **
2 ad	The Trust Now	*Expand service quality*	0.0001 **	0.0001 **
2 ae	The Trust Now	*Other (specify)*	0 **	0 **
2 af	The Trust Ideally	*Break-even financially*	0 **	0 **
2 ag	The Trust Ideally	*Meintain service volume*	0.0002 **	0.0001 **
2 ah	The Trust Ideally	*Maintain service quality*	0.0103 *	0.0176 *
2 aj	The Trust Ideally	*Expand revenue*	0.0645	0.1164
2 ak	The Trust Ideally	*Expand service volume*	0.3716	0.3389
2 am	The Trust Ideally	*Expand service quality*	0.0937	0.1966
2 an	The Trust Ideally	*Other (specify)*	0.3304	0.2498

* = Significant at 0.05 level but not at 0.01
** = Significant at 0.01 level

National Survey: Two Groups: Doctors and Managers - Mean Ranking Scores

	Priorities Perceived as Belonging to :	*Objective*	Sample Mean	Doctors' Mean	Managers' Mean	Difference
2 a	You	*Break-even financially*	2.836	3.908	2.037	1.9
2 b	You	*Maintain service volume*	2.662	2.754	2.593	0.2
2 c	You	*Maintain service quality*	2.065	1.776	2.281	-0.5
2 d	You	*Expand revenue*	3.721	4.076	3.457	0.6
2 e	You	*Expand service volume*	3.449	3.472	3.433	0.0
2 f	You	*Expand service quality*	2.505	2.124	2.792	-0.7
2 g	You	*Other (specify)*	3.209	2.97	3.459	-0.5
2 h	Most Service/Business Managers	*Break-even financially*	1.856	1.557	2.08	-0.5
2 j	Most Service/Business Managers	*Maintain service volume*	2.43	2.505	2.374	0.1
2 k	Most Service/Business Managers	*Maintain service quality*	2.733	3.067	2.484	0.6
2 m	Most Service/Business Managers	*Expand revenue*	3.019	2.798	3.185	-0.4
2 n	Most Service/Business Managers	*Expand service volume*	3.329	3.419	3.262	0.2
2 p	Most Service/Business Managers	*Expand service quality*	3.552	3.968	3.241	0.7
2 q	Most Service/Business Managers	*Other (specify)*	4.887	5.223	4.545	0.7
2 r	Most Consultants	*Break-even financially*	4.566	4.601	4.54	0.1
2 s	Most Consultants	*Maintain service volume*	2.678	2.565	2.762	-0.2
2 t	Most Consultants	*Maintain service quality*	2.07	1.756	2.3	-0.5
2 u	Most Consultants	*Expand revenue*	4.153	4.245	4.085	0.2
2 v	Most Consultants	*Expand service volume*	2.962	3.154	2.821	0.3
2 w	Most Consultants	*Expand service quality*	2.224	2.126	2.297	-0.2
2 x	Most Consultants	*Other (specify)*	3.048	3.263	2.847	0.4
2 y	The Trust Now	*Break-even financially*	1.487	1.479	1.492	-0.0
2 z	The Trust Now	*Maintain service volume*	2.58	2.648	2.53	0.1
2 aa	The Trust Now	*Maintain service quality*	2.876	3.107	2.707	0.4
2 ab	The Trust Now	*Expand revenue*	2.881	2.766	2.966	-0.2
2 ac	The Trust Now	*Expand service volume*	3.407	3.459	3.369	0.1
2 ad	The Trust Now	*Expand service quality*	3.659	3.939	3.452	0.5
2 ae	The Trust Now	*Other (specify)*	4.42	4.814	4.04	0.8
2 af	The Trust Ideally	*Break-even financially*	2.488	2.911	2.177	0.7
2 ag	The Trust Ideally	*Maintain service volume*	3.087	3.175	3.023	0.2
2 ah	The Trust Ideally	*Maintain service quality*	2.683	2.609	2.738	-0.1
2 aj	The Trust Ideally	*Expand revenue*	3.221	3.316	3.152	0.2
2 ak	The Trust Ideally	*Expand service volume*	2.979	3.024	2.945	0.1
2 am	The Trust Ideally	*Expand service quality*	2.334	2.265	2.385	-0.1
2 an	The Trust Ideally	*Other (specify)*	3.287	3.382	3.196	0.2

National Survey: Two Groups: Doctors and Managers - Mean Ranking Scores

	Priorities Perceived as Belonging to :	*Objective*	Doctors' Mean	anager Mean	ifferenc	ANOVA significance 5%* only and 1%**
2 a	You	*Break-even financially*	3.908	2.037	1.9	0 **
2 b	You	*Maintain service volume*	2.754	2.593	0.2	0.0477 *
2 c	You	*Maintain service quality*	1.776	2.281	-0.5	0 **
2 d	You	*Expand revenue*	4.076	3.457	0.6	0 **
2 e	You	*Expand service volume*	3.472	3.433	0.0	0.6714
2 f	You	*Expand service quality*	2.124	2.792	-0.7	0 **
2 g	You	*Other (specify)*	2.97	3.459	-0.5	0.0004**
2 h	Most Service/Business Managers	*Break-even financially*	1.557	2.08	-0.5	0 **
2 j	Most Service/Business Managers	*Maintain service volume*	2.505	2.374	0.1	0.063
2 k	Most Service/Business Managers	*Maintain service quality*	3.067	2.484	0.6	0 **
2 m	Most Service/Business Managers	*Expand revenue*	2.798	3.185	-0.4	0 **
2 n	Most Service/Business Managers	*Expand service volume*	3.419	3.262	0.2	0.0536
2 p	Most Service/Business Managers	*Expand service quality*	3.968	3.241	0.7	0 **
2 q	Most Service/Business Managers	*Other (specify)*	5.223	4.545	0.7	0 **
2 r	Most Consultants	*Break-even financially*	4.601	4.54	0.1	0.4216
2 s	Most Consultants	*Maintain service volume*	2.565	2.762	-0.2	0.0110*
2 t	Most Consultants	*Maintain service quality*	1.756	2.3	-0.5	0 **
2 u	Most Consultants	*Expand revenue*	4.245	4.085	0.2	0.0746
2 v	Most Consultants	*Expand service volume*	3.154	2.821	0.3	0.0001 **
2 w	Most Consultants	*Expand service quality*	2.126	2.297	-0.2	0.0150 *
2 x	*Most Consultants*	*Other (specify)*	3.263	2.847	*0.4*	*0.0004* **
2 y	The Trust Now	*Break-even financially*	1.479	1.492	-0.0	0.7873
2 z	The Trust Now	*Maintain service volume*	2.648	2.53	0.1	0.1176
2 aa	The Trust Now	*Maintain service quality*	3.107	2.707	0.4	0 **
2 ab	The Trust Now	*Expand revenue*	2.766	2.966	-0.2	0.0116 *
2 ac	The Trust Now	*Expand service volume*	3.459	3.369	0.1	0.2815
2 ad	The Trust Now	*Expand service quality*	3.939	3.452	0.5	0 **
2 ae	The Trust Now	*Other (specify)*	4.814	4.04	0.8	0 **
2 af	The Trust Ideally	*Break-even financially*	2.911	2.177	0.7	0 **
2 ag	The Trust Ideally	*Maintain service volume*	3.175	3.023	0.2	0.1143
2 ah	The Trust Ideally	*Maintain service quality*	2.609	2.738	-0.1	0.16
2 aj	The Trust Ideally	*Expand revenue*	3.316	3.152	0.2	0.1026
2 ak	The Trust Ideally	*Expand service volume*	3.024	2.945	0.1	0.391
2 am	The Trust Ideally	*Expand service quality*	2.265	2.385	-0.1	0.1298
2 an	The Trust Ideally	*Other (specify)*	3.382	3.196	0.2	0.1566

Comparison of Hospital A, Hospital B and National Survey: All Disciplines

Q2	Priorities Perceived as Belonging to :	Objective	National Mean	A & B Mean	Difference	B Mean	A Mean	Differenc	A & B ANOVA
a	You	Break-even financially	2.84	2.9	-0.1	3.15	2.68	0.5	Signif.
b	You	Maintain service volume	2.66	2.33	0.3	2.25	2.41	-0.2	@ 5%
c	You	Maintain service quality	2.07	1.9	0.2	1.85	1.95	-0.1	
d	You	Expand revenue	3.72	3.51	0.2	3.37	3.64	-0.3	
e	You	Expand service volume	3.45	3.44	0.1	3.26	3.59	-0.3	
f	You	Expand service quality	2.51	2.9	-0.4	2.89	2.91	-0.0	
g	You	Other (specify)	3.21	4.71	-1.5	5.17	4.45	0.7	
h	Most Service/Business Managers	Break-even financially	1.86	1.9	-0.0	1.50	2.30	-0.8	
j	Most Service/Business Managers	Maintain service volume	2.43	2.83	-0.4	3.15	2.50	0.7	
k	Most Service/Business Managers	Maintain service quality	2.73	3.2	-0.5	4.00	2.40	1.6	✓
m	Most Service/Business Managers	Expand revenue	3.02	2.62	0.4	2.00	3.20	-1.2	✓
n	Most Service/Business Managers	Expand service volume	3.33	3	0.3	2.53	3.45	-0.9	✓
p	Most Service/Business Managers	Expand service quality	3.55	3.56	-0.1	3.79	3.35	0.4	
q	Most Service/Business Managers	Other (specify)	4.89	5.77	-0.9	6.40	5.38	1.0	
r	Most Consultants	Break-even financially	4.57	4.35	0.2	4.05	4.62	-0.6	
s	Most Consultants	Maintain service volume	2.68	2.45	0.2	2.11	2.76	-0.7	
t	Most Consultants	Maintain service quality	2.07	2.18	-0.1	2.11	2.24	-0.1	
u	Most Consultants	Expand revenue	4.15	3.97	0.2	3.17	4.67	-1.5	✓
v	Most Consultants	Expand service volume	2.96	3.13	-0.2	2.83	3.38	-0.6	
w	Most Consultants	Expand service quality	2.22	2.67	-0.4	2.50	2.81	-0.3	
x	Most Consultants	Other (specify)	3.05	4.43	-1.4	4.75	4.30	0.5	
y	The Trust Now	Break-even financially	1.49	1.53	-0.0	1.26	1.76	-0.5	
z	The Trust Now	Maintain service volume	2.58	2.98	-0.4	2.79	3.14	-0.4	
aa	The Trust Now	Maintain service quality	2.88	3.05	-0.2	3.37	2.76	0.6	
ab	The Trust Now	Expand revenue	2.88	2.31	0.6	1.83	2.71	-0.9	✓
ac	The Trust Now	Expand service volume	3.41	2.97	0.4	2.72	3.19	-0.5	
ad	The Trust Now	Expand service quality	3.66	3.62	0.0	3.72	3.52	0.2	
ae	The Trust Now	Other (specify)	4.42	5.92	-1.5	6.75	5.56	1.2	
af	The Trust Ideally	Break-even financially	2.49	2.8	-0.3	3.26	2.38	0.9	
ag	The Trust Ideally	Maintain service volume	3.09	3.03	0.1	3.16	2.90	0.3	
ah	The Trust Ideally	Maintain service quality	2.68	2.53	0.2	2.58	2.48	0.1	
aj	The Trust Ideally	Expand revenue	3.22	2.62	0.6	2.67	2.57	0.1	
ak	The Trust Ideally	Expand service volume	2.98	2.82	0.2	2.61	3.00	-0.4	
am	The Trust Ideally	Expand service quality	2.33	2.26	0.1	2.11	2.38	-0.3	
an	The Trust Ideally	Other (specify)	3.29	4.31	-1.0	4.67	4.20	0.5	

Appendix 4

Comparison of Hospital A, Hospital B and National Survey: Doctors' Views

Q2	Priorities Perceived as Belonging to :	*Objective*	National Mean	A & B Mean	Difference	B Mean	A Mean	Differenc
a	You	*Break-even financially*	3.91	3.78	0.1	3.79	3.78	0.1
b	You	*Maintain service volume*	2.75	2.39	0.4	2.50	2.22	0.3
c	You	*Maintain service quality*	1.78	1.7	0.1	1.71	1.67	0.0
d	You	*Expand revenue*	4.08	3.87	0.2	3.43	4.56	-1.1
e	You	*Expand service volume*	3.47	3.43	0.0	3.29	3.67	-0.4
f	You	*Expand service quality*	2.12	2.48	-0.4	2.57	2.33	0.2
g	You	*Other (specify)*	2.97	4.82	-1.9	5.17	4.40	0.8
h	Most Service/Business Managers	*Break-even financially*	1.56	1.43	0.1	1.36	1.57	-0.2
j	Most Service/Business Managers	*Maintain service volume*	2.51	3.33	-0.8	3.50	3.00	0.5
k	Most Service/Business Managers	*Maintain service quality*	3.07	3.67	-0.6	4.43	2.14	2.3
m	Most Service/Business Managers	*Expand revenue*	2.80	2.05	0.7	1.79	2.57	-0.8
n	Most Service/Business Managers	*Expand service volume*	3.42	2.71	0.7	2.50	3.14	-0.6
p	Most Service/Business Managers	*Expand service quality*	3.97	3.57	0.4	3.86	3.00	0.9
q	Most Service/Business Managers	*Other (specify)*	5.22	6.5	-1.3	6.40	6.67	-0.3
r	Most Consultants	*Break-even financially*	4.60	4.19	0.4	4.15	4.25	-0.1
s	Most Consultants	*Maintain service volume*	2.57	2.24	0.3	2.00	2.63	-0.6
t	Most Consultants	*Maintain service quality*	1.76	1.95	-0.2	2.00	1.88	0.1
u	Most Consultants	*Expand revenue*	4.25	3.52	0.7	3.23	4.00	-0.8
v	Most Consultants	*Expand service volume*	3.15	3.33	-0.2	3.31	3.38	-0.1
w	Most Consultants	*Expand service quality*	2.13	2.62	-0.5	2.69	2.50	0.2
x	Most Consultants	*Other (specify)*	3.26	4.43	-1.2	4.75	4.00	0.8
y	The Trust Now	*Break-even financially*	1.48	1.52	-0.0	1.38	1.75	-0.4
z	The Trust Now	*Maintain service volume*	2.65	3.38	-0.7	3.23	3.63	-0.4
aa	The Trust Now	*Maintain service quality*	3.11	3.43	-0.3	4.00	2.50	1.5
ab	The Trust Now	*Expand revenue*	2.77	2.05	0.7	1.62	2.75	-1.1
ac	The Trust Now	*Expand service volume*	3.46	2.57	0.9	2.38	2.88	-0.5
ad	The Trust Now	*Expand service quality*	3.94	3.29	0.6	3.69	2.63	1.1
ae	The Trust Now	*Other (specify)*	4.81	6.71	-1.9	6.75	6.67	0.1
af	The Trust Ideally	*Break-even financially*	2.91	3.1	-0.2	3.23	2.88	0.4
ag	The Trust Ideally	*Maintain service volume*	3.18	3.24	-0.1	3.15	3.38	-0.2
ah	The Trust Ideally	*Maintain service quality*	2.61	2.52	0.1	2.38	2.75	-0.4
aj	The Trust Ideally	*Expand revenue*	3.32	2.86	0.5	2.92	2.75	0.2
ak	The Trust Ideally	*Expand service volume*	3.02	2.67	0.4	2.77	2.50	0.3
am	The Trust Ideally	*Expand service quality*	2.27	1.9	0.4	2.00	1.75	0.3
an	The Trust Ideally	*Other (specify)*	3.38	4.29	-0.9	4.67	4.00	0.7

Comparison of Hospital A, Hospital B and National Survey: Managers' Views

Q2	Priorities Perceived as Belonging to :	*Objective*	National Mean	A & B Mean	Difference	B Mean	A Mean	Differenc
a	You	*Break-even financially*	2.04	1.84	0.2	1.67	1.92	-0.3
b	You	*Maintain service volume*	2.59	2.26	0.3	1.67	2.54	-0.9
c	You	*Maintain service quality*	2.28	2.16	0.1	2.17	2.15	0.0
d	You	*Expand revenue*	3.46	3.06	0.4	3.20	3.00	0.2
e	You	*Expand service volume*	3.43	3.44	-0.1	3.20	3.54	-0.3
f	You	*Expand service quality*	2.79	3.44	-0.6	3.80	3.31	0.5
g	You	*Other (specify)*	3.46	4.5	-1.0		4.50	-4.5
h	Most Service/Business Managers	*Break-even financially*	2.08	2.42	-0.3	1.83	2.69	-0.9
j	Most Service/Business Managers	*Maintain service volume*	2.37	2.26	0.1	2.33	2.23	0.1
k	Most Service/Business Managers	*Maintain service quality*	2.48	2.68	-0.2	3.00	2.54	0.5
m	Most Service/Business Managers	*Expand revenue*	3.19	3.28	-0.1	2.60	3.54	-0.9
n	Most Service/Business Managers	*Expand service volume*	3.26	3.33	-0.1	2.60	3.62	-1.0
p	Most Service/Business Managers	*Expand service quality*	3.24	3.56	-0.3	3.60	3.54	0.1
q	Most Service/Business Managers	*Other (specify)*	4.55	4.6	-0.1			0.0
r	Most Consultants	*Break-even financially*	4.54	4.53	0.0	3.83	4.85	-1.0
s	Most Consultants	*Maintain service volume*	2.76	2.68	0.1	2.33	2.85	-0.5
t	Most Consultants	*Maintain service quality*	2.30	2.42	-0.1	2.33	2.46	-0.1
u	Most Consultants	*Expand revenue*	4.09	4.5	-0.4	3.00	5.08	-2.1
v	Most Consultants	*Expand service volume*	2.82	2.89	-0.1	1.60	3.38	-1.8
w	Most Consultants	*Expand service quality*	2.30	2.72	-0.4	2.00	3.00	-1.0
x	Most Consultants	*Other (specify)*	2.85	4.43	-1.6		4.43	-4.4
y	The Trust Now	*Break-even financially*	1.49	1.53	-0.0	1.00	1.77	-0.8
z	The Trust Now	*Maintain service volume*	2.53	2.53	0.0	1.83	2.85	-1.0
aa	The Trust Now	*Maintain service quality*	2.71	2.63	0.1	2.00	2.92	-0.9
ab	The Trust Now	*Expand revenue*	2.97	2.61	0.4	2.40	2.69	-0.3
ac	The Trust Now	*Expand service volume*	3.37	3.44	-0.1	3.60	3.38	0.2
ad	The Trust Now	*Expand service quality*	3.45	4	-0.5	3.80	4.08	-0.3
ae	The Trust Now	*Other (specify)*	4.04	5	-1.0			0.0
af	The Trust Ideally	*Break-even financially*	2.18	2.47	-0.3	3.33	2.08	1.3
ag	The Trust Ideally	*Maintain service volume*	3.02	2.79	0.2	3.17	2.62	0.6
ah	The Trust Ideally	*Maintain service quality*	2.74	2.53	0.2	3.00	2.31	0.7
aj	The Trust Ideally	*Expand revenue*	3.15	2.33	0.8	2.00	2.46	-0.5
ak	The Trust Ideally	*Expand service volume*	2.95	3	-0.1	2.20	3.31	-1.1
am	The Trust Ideally	*Expand service quality*	2.39	2.67	-0.3	2.40	2.77	-0.4
an	The Trust Ideally	*Other (specify)*						

Comparison of Hospital A, Hospital B and National Survey: Comparison of Doctors' and Managers' Views

Q2	Priorities Perceived as Belonging to :	*Objective*	National Mean	A & B Mean	Difference	B Mean	A Mean	Differenc	A & B ANOVA
a	You	*Break-even financially*	3.91	2.04	1.9	3.78	1.84	1.9	✓
b	You	*Maintain service volume*	2.75	2.59	0.2	2.39	2.26	0.1	
c	You	*Maintain service quality*	1.78	2.28	-0.5	1.7	2.16	-0.5	
d	You	*Expand revenue*	4.08	3.46	0.6	3.87	3.06	0.8	
e	You	*Expand service volume*	3.47	3.43	0.0	3.43	3.44	-0.1	
f	You	*Expand service quality*	2.12	2.79	-0.7	2.48	3.44	-1.0	
g	You	*Other (specify)*	2.97	3.46	-0.5	4.82	4.5	0.3	
h	Most Service/Business Managers	*Break-even financially*	1.56	2.08	-0.5	1.43	2.42	-1.0	✓
j	Most Service/Business Managers	*Maintain service volume*	2.51	2.37	0.1	3.33	2.26	1.1	✓
k	Most Service/Business Managers	*Maintain service quality*	3.07	2.48	0.6	3.67	2.68	1.0	✓
m	Most Service/Business Managers	*Expand revenue*	2.80	3.19	-0.4	2.05	3.28	-1.2	✓
n	Most Service/Business Managers	*Expand service volume*	3.42	3.26	0.2	2.71	3.33	-0.6	
p	Most Service/Business Managers	*Expand service quality*	3.97	3.24	0.7	3.57	3.56	0.0	
q	Most Service/Business Managers	*Other (specify)*	5.22	4.55	0.7	6.5	4.6	1.9	
r	Most Consultants	*Break-even financially*	4.60	4.54	0.1	4.19	4.53	-0.3	
s	Most Consultants	*Maintain service volume*	2.57	2.76	-0.2	2.24	2.68	-0.4	
t	Most Consultants	*Maintain service quality*	1.76	2.30	-0.5	1.95	2.42	-0.5	
u	Most Consultants	*Expand revenue*	4.25	4.09	0.2	3.52	4.5	-1.0	
v	Most Consultants	*Expand service volume*	3.15	2.82	0.3	3.33	2.89	0.4	
w	Most Consultants	*Expand service quality*	2.13	2.30	-0.2	2.62	2.72	-0.1	
x	Most Consultants	*Other (specify)*	3.26	2.85	0.4	4.43	4.43	0.0	
y	The Trust Now	*Break-even financially*	1.48	1.49	-0.0	1.52	1.53	-0.0	
z	The Trust Now	*Maintain service volume*	2.65	2.53	0.1	3.38	2.53	0.9	✓
aa	The Trust Now	*Maintain service quality*	3.11	2.71	0.4	3.43	2.63	0.8	
ab	The Trust Now	*Expand revenue*	2.77	2.97	-0.2	2.05	2.61	-0.6	
ac	The Trust Now	*Expand service volume*	3.46	3.37	0.1	2.57	3.44	-0.9	
ad	The Trust Now	*Expand service quality*	3.94	3.45	0.5	3.29	4	-0.7	
ae	The Trust Now	*Other (specify)*	4.81	4.04	0.8	6.71	5	1.7	✓
af	The Trust Ideally	*Break-even financially*	2.91	2.18	0.7	3.1	2.47	0.6	
ag	The Trust Ideally	*Maintain service volume*	3.18	3.02	0.2	3.24	2.79	0.5	
ah	The Trust Ideally	*Maintain service quality*	2.61	2.74	-0.1	2.52	2.53	-0.0	
aj	The Trust Ideally	*Expand revenue*	3.32	3.15	0.2	2.86	2.33	0.5	
ak	The Trust Ideally	*Expand service volume*	3.02	2.95	0.1	2.67	3	-0.3	
am	The Trust Ideally	*Expand service quality*	2.27	2.39	-0.1	1.9	2.67	-0.8	
an	The Trust Ideally	*Other (specify)*	3.38	3.20	0.2	4.29		4.3	

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